GUIDELINES FOR THE EMPOWERMENT OF PROFESSIONAL NURSES IN THE PUBLIC HOSPITALS OF ONE DISTRICT IN THE MPUMALANGA PROVINCE

by

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Student number: 04623606

DECLARATION

I declare that the **GUIDELINES FOR THE EMPOWERMENT OF PROFESSIONAL NURSES IN THE PUBLIC HOSPITALS OF ONE DISTRICT IN THE MPUMALANGA PROVINCE** hereby submitted to the University of South Africa, for the degree of the Doctor of Literature and Philosophy in Health Studies has not been submitted before for any other degree at any other institution, and that it is my work and all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

17 February 2017

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CSP LEPHOKO **DATE**

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ABSTRACT

The purpose of the study was to investigate the perceived lack of empowerment of registered nurses in the Mpumalanga Province. To determine the reasons for the perceived lack of empowerment and the effect thereof on professional conduct after which empowerment guidelines would be developed which managers can apply in order to enhance the empowerment of registered nurses in their service, and in turn cultivate confident nurse leaders.

The main study objectives were to describe what empowerment entails, and its effect on professional conduct in the workplace; explore the level of empowerment among nurse managers and registered nurses; ascertain the effect of perceived powerlessness on the professional conduct and behaviour of nurse managers and registered nurses; establish the reasons for the perceived lack of empowerment among nurse managers and registered nurses; determine if there is a difference in the way in which nurse managers and registered nurses perceive the existing empowerment in their public hospitals and to develop empowerment guidelines for nurse managers and registered nurses.

Kanter's *Theory of Structural Empowerment* formed the basis of the study and guided the structure of the report. This theory contains three components, each with several dimensions resulting in 14 factors to be tested.

A quantitative research approach, with an exploratory and descriptive design was used. Using a researcher-developed questionnaire as the data collection instrument. The site

population consisted of one randomly selected district containing eight public hospitals in the Mpumalanga Province. All nurse managers and registered nurses in these hospitals were invited to participate in the study.

The researcher delivered the questionnaires to the respondents of the eight hospitals that met the inclusion criteria. Two hundred and sixty seven (267) completed questionnaires were collected upon completion resulting in a response rate of 30.2%.

Descriptive and inferential statistics were used to analyse the data. Generally, the results indicated that the majority of the respondents felt empowered with the dimensions contained under the *structural empowerment*, *psychological empowerment* and *positive work behaviours and attitudes* components *of* Kanter's Theory. However the respondents noted that they had limited resources. According to the results those nurse managers and registered nurses who felt empowered, scored strongly in the areas of *structura*l and *psychological empowerment*. The empowerment guidelines were developed for dimensions which were found to be non-empowering to assist nurse managers and registered nurses in creating workplace environments that could enhance the empowerment of registered nurses in their hospitals.

Keywords

Kanter's *Theory of Structural Empowerment*, assertiveness, disempowerment, empowerment, guidelines, helplessness, nursing, nurse manager, organisation, organisational structure, power, powerlessness and registered nurse.

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LIST OF ABBREVIATIONS

AGRE	Appraisal of Guidelines Research and Evaluation Tool
DENOSA	Democratic Nursing Organisation of South Africa
PMDMC	Performance Management Development Moderation Committee
SANC	South African Nursing Council

CHAPTER 1

RATIONALE AND OVERVIEW OF THE STUDY

1.1 INTRODUCTION

Hospitals and community health care centres employ various categories of nurses that provide nursing care to patients**.** These centres are expected to ensure that there are good workplace empowerment structures that support employees, reduce stress and increase employee commitment to the achievement of organisational outcomes and improved patient care (Wagner, Cummings, Smith, Olson, Anderson & Warren 2010:449). Empowerment refers to giving individuals the authority, responsibility and freedom to act on what they know, instilling in them the belief and confidence in their own abilities to achieve and succeed (Huber 2010:261).

Nurse managers can promote the empowerment of registered nurses, by ensuring that job-related empowerment structures and good working environments are available. Empowerment structures include access to information, support, resources and opportunities to learn and for growth (Laschinger, Finegan & Wilk 2009:229). The availability of empowering structures can strengthen the individual's position and provide a sense of efficacy to get things done in the organisation (Donahue, Piazza, Griffin, Dykes & Fitzpatrick 2008:3). Good working environments contribute to a higher sense of empowerment, which in turn, contributes to preventing burnout (Hochwalder 2007:205). Nursing work environments with higher levels of autonomy are associated with increased performance and improved patient outcomes (Weston 2010:2). The above noted authors clearly indicate the importance of creating a good working environment that promotes empowerment of nurses. The study is concerned with the empowerment of nurse managers and registered nurses who work in public hospitals.

1.2 BACKGROUND TO THE PROBLEM

Empowerment of employees in the healthcare organisation is important because it ensures that nurse managers and registered nurses have the necessary power to

direct, manage and to make decisions related to their work that will serve the organisation well (Schermerhorn, Osborn, Uhl-Bien & Hunt 2012:275).

The lack of empowerment or disempowerment of nurses would therefore have a negative impact on the functioning of their organisations, and the realisation of organisational goals. Nurses, who are not empowered, will not have the power to direct and control activities and responsibilities effectively within their work environments.

According to Polit and Beck (2012:741), a problem is an enigmatic or perplexing condition that can be investigated through disciplined inquiry. Brink, Van der Walt and Van Rensburg (2012:62) state that a research problem can be developed from many sources. These sources include: clinical practice, literature, theory, ethical dilemmas, observed health and illness patterns, and interactions with colleagues, students and individuals. In order to reach the problem statement, background information will now be provided to explain the situation which creates the impression that nurses feel disempowered within the context of the study.

The researcher is a nurse educator at the Mpumalanga College of Nursing and has multiple academic obligations which create opportunities for interaction, discussion and observation. The researcher participates in the meetings of the provincial nurse educators, the College Council and the Senate where academic and clinical practice issues are discussed.

Mpumalanga College of Nursing is situated in the Mpumalanga Province with 12 nursing schools which are affiliated to the Mpumalanga College of Nursing. These nursing schools are situated in the public hospitals. The nursing schools provide Bridging Course training and other programmes for nurses. In addition there are five hospitals that do not have nursing schools but are also affiliated to the Mpumalanga College of Nursing in terms of facilitating work integrated learning.

Senate meetings are attended by the five clinical preceptors whose hospitals do not have nursing schools. These hospitals are utilised for clinical teaching and placement of nurse learners. Principals of the 12 nursing schools also attend Senate meetings. Nursing schools provide theoretical teaching, clinical teaching and placement of nurse learners. All the three districts of the Mpumalanga Province are represented on the

College Council by one nursing service manager representing the three districts. However two principals from the twelve nursing schools represent the other ten principals on Council. The meetings are held quarterly. In these meetings reports on clinical practice are tabled and debated by the members.

In addition the researcher attends regular meetings with 19 lecturers and five heads of departments, as well as meetings of college management, which consists of human resource and academic sections respectively. During these meetings members have expressed the difficulties they experience in terms of not having sufficient information, often not being permitted to make decisions pertaining to their specific work area and the frequent lack of resources which hampers their service delivery.

The researcher also conducts departmental meetings with five team members who give reports about challenges that are experienced by learners in clinical facilities as well as challenges expressed by nurses working in the 17 clinical facilities situated in hospitals which are approved by the SANC for clinical practice learning for learner nurses. Furthermore the researcher participates in the accompaniment of learners in the clinical areas in order to ensure that theory is translated into practice. The accompaniment of learners in clinical areas created more opportunities for observations and enabled the researcher to monitor and interact with nursing unit managers and registered nurses noting the difficulties and limitations they encounter within the practical field.

The researcher is a member of the Democratic Nursing Organisation of South Africa (DENOSA). As a member, the researcher attends the Mpumalanga Nursing College DENOSA meetings where feedback is given by the shop steward who attends DENOSA's quarterly meetings held at the Mpumalanga Province Head office with other shop stewards representing nurses from the twelve regions of the Mpumalanga Province. Their feedback is thus based on the views and the experiences of a large group of nurses and often pertains to issues that make nurses feel helpless in delivering the quality of service they would wish to. It is as the result of these meetings, observations, and interactions of the researcher with nurses across a broad field that the researcher became aware of the reasons that are believed to be contributory factors to a feeling of being disempowerment that exists among nurse managers and registered nurses.

The following factors were mentioned by nurse managers and registered nurses as those which could be considered as disempowering:

Lack of adequate information: Information refers to data with meaning to some person who has interpreted or analysed it (Quick & Nelson 2013:245). On the other hand information is also viewed as a set of data that has been interpreted covering some facts of time, such as over the course of a day (Roussel 2013:501). Nurse managers and registered nurses expressed their concern about the insufficient, or lack of, adequate information they received in connection with policy changes and circulars from head office, performance feedback and lack of implementation of performance appraisal feedback and development planning.

Performance refers to a systematically planned process of evaluating and developing the performance of staff (Meyer, Naude, Shangase & Van Niekerk 2009:297). For instance, subordinates cited that they only received feedback on their performance when they had made mistakes, but none when they had performed well.

Lack of participative decision-making: Participative decision-making refers to decision-making in which individuals who are affected by decisions influence the making of those decisions (Quick & Nelson 2013:739). The feeling among nurse managers and registered nurses is that decisions are centralised at the top and cascaded down to them without involving or consulting them about the feasibility of those decisions that they must implement. An example of this is when top management issues circulars indicating a cut in resources without consideration of the subordinates' job-related needs, or restricting employment of additional staff – even though there are vacancies on the approved staff establishment – leading to high workloads for the existing nursing staff. This practice, which excludes the involvement of nurses in decision-making, leads to a sense of frustration and powerlessness. Whereas if employees are involved in decision-making they can contribute to decisions that affect their jobs, such as setting work goals and solving productivity and quality problems (Robbins, Judge & Campbell 2010:191).

Lack of adequate resources: Resources refer to time, material, money, supplies and equipment necessary to accomplish organisational goals (Wagner et al 2010:449). Resources also refer to people, people with specific knowledge, skills and abilities

(Smit, Cronje, Brevis & Vrba 2011:4). Organisations are responsible for ensuring that there are enough resources such as human and material resources, by recruiting and hiring staff with knowledge and skills to perform the job, in line with organisation's policies, procedures and relevant laws (Finkelman 2012:272). Resources that are of concern to nurses include the shortage of nurses and medication, stationery and cleaning materials that are in short supply. Furthermore, the inability of certain hospitals to pay their suppliers and service providers for services rendered such as water and electricity, telephone and internet usage, stationery, and agency staff inhibits the optimal functioning of health facilities which leads to poor patient care and contributes to a sense of powerlessness among nurses.

Ivancevich, Konopaske and Matteson (2014:340) state that in an organisation top level managers have the power and obligation to allocate resources to lower level managers in order for them to enable and enhance the accomplishment of organisational goals by lower level practitioners. Nurses cannot effectively practise without the right resources, sufficient caregivers, supplies and supporting systems. According to Weston (2010:5), nurses should exercise influence over the acquisition of required resources and the development of policies for their practice.

Lack of support: Wagner et al (2010:449) view support as constructive feedback and guidance by supervisors, peers and subordinates. Robbins et al (2010:64) state that people perceive their organisation as supportive when rewards are deemed fair, where they have a voice in decision-making and their supervisors are supportive. The absence of constructive feedback by supervisors is interpreted as a limitation in assisting nurses to improve their performance. Lack of support within a place of work is perceived as the inability of the organisation to provide satisfactory working environments and conditions which are, for example visible in abnormal nurse-patient ratios that leads to poor patient care and overworked staff. Inadequate facilities for staff – such as no restrooms, or no space for safekeeping of personal belongings when they are on duty, contribute to a feeling of lack of support. An institution that supports employees reduces stress and increases employee commitment, improved organisational outcomes and improved patient care (Wagner et al 2010:449).

Lack of commitment by supervisors: Commitment refers to a state of being emotionally impelled and feeling passionate about one's dedication to a project or event

(Yoder-Wise 2007:601). Supervisors' lack of commitment is apparent in their unwillingness to assist subordinates who are faced with challenging tasks or patient needs, or when supervisors show favouritism to nurses who are not performing well, and not taking disciplinary action because of personal relationships they have with the supervisor.

Nurses who perceive a lack of commitment and dedication from their supervisors become despondent, feel helpless and may resort to being submissive rather than challenging the situation. Lack of organisational commitment towards employees creates conflict with personal and family needs, aspirations for learning, and the need for appreciation, fairness, adequate monetary benefits, often leading to personal problems and poor relations with co-workers (Guleryuz, Guney, Aydin & Asan 2008:1627).

Lack of opportunity for training and development: Development refers to the process by which corporate management stimulates the motivation of employees to perform productively so that they can provide quality nursing care services to clients and also to keep the heath care organisation reputable (Roussel 2013:325). Nurse managers and registered nurses perceive lack of training and development opportunities as the result of budgetary constraints and restrictive organisational policies that stipulate that only a designated number of people may attend a particular course(s). They believe that the lack of training and development restricts their personal and professional growth and the acquisition of skills and expertise they need to perform their work.

In some hospitals, nurse managers and registered nurses are allocated to specific units on a permanent basis. The zoning system that confines nurses to specific units is perceived by some nurses to be restrictive, withholding them from the opportunity to gain experience from working with certain doctors, and specialists, as well as patients with different illnesses. It is important to promote training and staff development in the institution and in the nursing units through in-service education, continuous education and by assisting all staff with career development (Meyer et al 2009:254).

Lack of assertiveness: Assertiveness means expressing one's own position to another without inhibiting the rights of others (Huber 2010:262). Luthans (2011:436) defines

assertiveness as the degree to which individuals are assertive, confrontational, and aggressive in their relationships with others. Assertiveness is also seen as the use of a directive and forceful approach such as demanding compliance with requests, repeating reminders, ordering individuals to do what is asked, and pointing out rules in order to achieve compliance (Jooste 2011:127).

It seems as if registered nurses experience a lack of assertiveness in their units because they find doing the following difficult: challenging doctors' decisions regarding prescribed treatment which might lead to medico-legal risks; performing tasks which are above their scope of practice – such as putting up intravenous infusions and collecting blood specimens from patients when faced with challenging clinical situations, and in cases of an emergency where the doctor is unavailable. They are unable to stand up to doctors and supervisors who are unapproachable and who do not accept their views regarding patient care and treatment. Lack of assertiveness is also visible when nurses fail to express their concerns regarding the need for adequate equipment, supplies and personnel.

Powerlessness: Powerlessness of nurses can be a problem in an organisation because powerless managers often create an ineffective, petty, dictatorial and rule-minded management style (Marquis & Huston 2012:284). Powerlessness occurs when an individual has little or no access to the bases of interpersonal or structural power (Ivancevich et al 2014:357).

Should the nurses experience a sense of disempowerment, as is illustrated above, it would not be possible for them to function to their full capacity with reciprocal benefits for the institution and its patients. By investigating this problem, and developing guidelines that nurse managers can implement in their respective hospitals to enhance the empowerment of registered nurses, a positive contribution could be made to a conducive work environment and confident nurse leaders.

1.3 PROBLEM STATEMENT

From the background information, it is evident that there are contributory factors within the Mpumalanga public hospital environment that are perceived as being disempowering by the registered nurses. The main research problem for this study is

the perceived lack of empowerment among registered nurses in public hospitals of the Mpumalanga Province, and the effect thereof on their functioning. Brink et al (2012:61) describe a research problem as an area of concern in which there is a gap, or a situation in need of a solution, improvement or alteration, or in which there is a discrepancy between the way things are and the way they ought to be.

The following research questions arise:

- What does empowerment entail?
- What is the level of empowerment among nurse managers and registered nurses?
- What effect does powerlessness have on the professional conduct and behaviour of nurse managers and registered nurses?
- What are the reasons for the said nurses feeling disempowered?
- Is there a difference in the way in which nurse managers and registered nurses?
- How can empowerment of registered nurses be enhanced?

1.4 PURPOSE OF THE STUDY

The purpose of the study is to determine what empowerment encompasses and to establish the reasons for the perceived lack of empowerment of registered nurses. Furthermore, to develop empowerment guidelines which managers can apply in order to enhance the empowerment of registered nurses in their service, and in turn cultivate confident nurse leaders.

1.4.1 Objectives of the study

The objectives of the study are to

- describe what empowerment entails, and its effect on professional conduct in the workplace
- explore the level of empowerment among nurse managers and registered nurses
- ascertain the effect of powerlessness on the professional conduct and behaviour of nurse managers and registered nurses

- establish the reasons for the perceived lack of empowerment among nurse managers and registered nurses
- determine if there is a difference in the way in which nurse managers and registered nurses perceive the existing empowerment in their public hospitals
- develop empowerment guidelines for nurse managers and registered nurses

1.5 ASSUMPTION

Assumptions are basic principles that are accepted on faith, taken for granted, or assumed to be true without proof or verification. They determine the nature of concepts, definitions, purposes and relationships. They are the basic underlying truths from which theoretic reasoning proceeds (Brink et al 2012:27). They are often based on logic or reason, where correctness or validity is taken for granted (Basavanthappa 2007:556).

The following assumption is relevant to this study: empowered employees are able to apply their knowledge, skills, attitudes and values in realising the aims and objectives of the organisation.

1.6 THEORETICAL FRAMEWORK

According to Brink et al (2012:218), a theoretical framework is a study framework based on prepositional statements from a theory or theories. It represents the reasoning on which the purposes of the proposed study are based (Basavanthappa 2007:107).

This study is concerned with the empowerment of registered nurses in the workplace. Nurse managers who support autonomous decision-making and provide better access to work empowerment structures play a major role in creating empowering environments (Lucas, Laschinger & Wong 2008:966).

In this study, Kanter's *Theory of Structural Empowerment* was used as a theoretical framework. This theory offers a useful theoretical framework for guiding nurse leaders' efforts to create empowering conditions (Lucas et al 2008:966). Kuokkanen, Suominen, Harkonen, Kukkurainen and Doran (2009:117) describe empowerment as associated with personnel management, shared responsibilities, self-efficacy and good outcomes.

It is viewed as the transmission of power in an organisation to those who are less powerful (Ergeneli, Ari & Metin 2007:42).

Lucas et al (2008:965) explain that Kanter's *Theory of Structural Empowerment* is divided into three components, namely: structural empowerment, which includes the dimensions of opportunity, information, support, resources, formal power and informal power. Component two is concerned with psychological empowerment. It includes meaning, confidence, autonomy and impact as dimensions. Component three is concerned with positive work behaviours and attitudes and includes job satisfaction, commitment, low stress and low burnout as dimensions. Kanter's *Theory of Structural Empowerment* is appropriate for this study and will provide guidance in structuring the content of the study and the format of the report.

1.7 SIGNIFICANCE OF THE STUDY

The study should raise awareness of the need to empower nurse managers and registered nurses. The researcher is convinced that the study will make a significant contribution to the existing body of knowledge within the health care system. This study will lead to a better understanding of empowerment, the lack thereof and its effects on individual functioning. This study will also make managers aware of how structural empowerment, psychological empowerment and positive work behaviours and attitudes, could be utilised to create confident nurse leaders. The study aims to develop empowerment guidelines which managers can apply in order to enhance the empowerment of registered nurses in their service, and in turn cultivate confident nurse leaders.

The results will be used to

- provide information on factors that could contribute to the empowerment of nurse managers and registered nurses
- generate awareness among management teams of the importance of empowering nurse managers and registered nurses
- provide empowerment guidelines which were developed based on the findings of the study and literature review

1.8 DEFINITIONS OF KEY CONCEPTS

The terms contained in the research questions must be defined so that their meaning is clear to the researcher and to the reader of the research report (Brink et al 2012:91). The following concepts are derived from the research background, research questions and the relevant literature. The concepts and dimensions pertaining to the theoretical framework are discussed in Chapter 2.

The following concepts are relevant to this study:

- **Assertiveness**

Assertiveness means behaving in such a confident way that people notice you (*Longman Dictionary of Contemporary English for Advanced Learners* 2009:87) and expressing oneself in a direct, honest, and appropriate way, which does not infringe on other peoples' rights (Marquis & Huston 2012:429) but also giving others the chance to express themselves equally (Finkelman 2012:397). In this study, assertiveness means the ability of the person to express his/her feelings views on a matter without infringing on the rights of others and giving others a chance to express their feelings too.

- **Disempowerment/lack of empowerment**

Blanchard (2007:138) states that disempowerment occurs when people are not provided with the kind of leadership that responds to their needs. This occurs when they are under- or over-supervised. Causes of disempowerment include lack of feedback, lack of recognition, lack of clear performance expectations, unfair standards, being yelled at or blamed, reneging on commitments, being overworked and stressed out, lack of opportunities for development, lack of authority to do one's work and lack of challenging assignments. In this study, disempowerment means lack of opportunities for development as well as lack of suitable authority and resources to do one's work. In this study, the terms disempowerment and/or lack of empowerment will be used interchangeably.

- **Empowerment**

According to the *Longman Dictionary of Contemporary English for Advanced Learners* (2009:554), empowerment means to give someone more control over their own life or situation. Empowerment is further defined as a purposeful process of personal and professional development of managers and operational decision-makers to accomplish the abilities (knowledge, skills, attitudes and values) related to participative management (Muller, Bezuidenhout & Jooste 2011:73). In this study, empowerment refers to giving nurses more power (by means of sufficient information, resources, support and decision-making power) to control their job-related activities in order to promote personal and professional development and functioning.

- **Guidelines**

According to the *Longman Dictionary of Contemporary English for Advanced Learners* (2009:779), guidelines are rules or instructions about the best way to do something. Kelly and Tazbir (2014:327) state that guidelines are effective tools for improving the quality of care. The proposed outcome of investigating the state of empowerment of nurses in this study is to develop empowering guidelines which could be implemented by management to enhance the empowerment of nurse managers and registered nurses where it is needed.

- **Helplessness**

Helplessness (helpless) means being unable to act without help (*Oxford Popular School Dictionary* 2008:186). In respect of nurse managers and registered nurses, helplessness is a state in which a registered nurse is defenceless/lacking help, thus being unable to perform his/her duties. In this study, helplessness forms part of the feeling of being powerless.

- **Nursing**

According to the *Nursing Act No 33 of 2005*, as amended, nursing means a caring profession practised by a person registered under section 31 (South Africa 2005:s6). Nursing refers to the job or skill of looking after people who are ill, injured or old

(*Longman Dictionary of Contemporary English for Advanced Learners* 2009:554). In this study, nursing means a caring profession practised by a person registered under section 31 of the *Nursing Act No 33 of 2005* (South Africa 2005:s6).

- **Nurse manager**

A nurse manager is a person who is a registered nurse. The *Nursing Act No 33 of 2005*, as amended, defines a registered nurse as a person that is registered as such in terms of section 31 (South Africa 2005:s6). A nurse manager is a person who is a registered nurse with an additional qualification in nursing administration (a degree or diploma in Nursing Administration) and who is registered as such with the South African Nursing Council (SANC), or, could be a person who is registered as a registered nurse but does not hold a degree or diploma in Nursing Administration, yet functions as a nurse manager in her organisation

- **Nursing unit manager**

A nursing unit manager is a, registered nurse who uses scientific knowledge and skills to provide health care and treats healthcare users in order to achieve and to maintain health (Meyer et al 2009:3).

- **Organisation**

Organisation refers to a social entity that is goal directed and deliberately structured (Muller et al 2011:563). An organisation is also described by Jones (2007:42), as a group of persons with specific responsibilities who are acting together for the achievement of a specific purpose determined by the organisation. In this study, an organisation will refer to hospitals that form part of the research site population.

- **Organisational structure**

Organisational structure refers to the formal pattern of how people and jobs are grouped in an organisation (Ivancevich, Konopaske & Matteson 2008:529). In this study, organisational structure refers to the basic framework of formal relationships between responsibilities, tasks, and people in the organisation (Smit et al 2011:217). Line

function, authority structure and communication channels are determined by organisational structure and influence the delegation of power and decision-making authority.

- **Power**

Power is the ability to control or impose a situation or persons by directing and regulating the circumstances; it is also the ability to influence and thereby secure some modification in another party's decision or action (Muller et al 2011:390). Power refers to the ability to get things done, mobilise resources, to get and use whatever it is that a person needs for the goals he or she is attempting to meet (Manojlovich 2007:2). Power is derived from different sources such as positional power and referent power. In this study, power is viewed as the ability of a person to act and mobilise resources with the aim of achieving the goals of the organisation thus being empowered to make decisions and to act for the good of the organisation.

- **Powerlessness**

Powerlessness refers to a state of being frustrated (*Longman Dictionary of Contemporary English for Advanced Learners* 2009:137). It also refers to a lack of the resources, information, and decision-making prerogatives needed to be productive. Symptoms of powerlessness include being supervised very closely, lack of training and lack of orientation (Ivancevich et al 2014:346). In this study, powerlessness refers to the lack of power to be effective, the inability to act and having no voice in the management process and functions.

- **Professional nurse**

The *Nursing Act No 33 of 2005*, as amended, defines a professional nurse as a person that is registered as such in terms of section 30 (1) (South Africa 2005:s61). A person who is qualified and competent to independently practise comprehensive nursing in this manner, to the level as prescribed, and who is capable of assuming responsibility for such practice (South Africa 2005:s25).

- **Registered nurse**

According to the Government Notice No 36935 (2013:17) a registered nurse is a person who has completed the course and who meets the requirements prescribed in the regulation published under Government Notice No. R683 of 14 April 1989 leading to registration as a general nurse. The Scope of Practice of Registered Nurses R2598, states that a "registered person" shall mean a person who is registered as a nurse or midwife in terms of section 45(1) of the *Nursing Act No 33 of 2005*. The Scope of Practice of Registered Nurses R2598, states that a registered nurse shall perform certain acts or procedures which may be performed by scientifically based physical, chemical, psychological, social, educational and technological means applicable to health care practice (South Africa 2005:s2).

In accordance with the definition of the SANC's Scope of Practice R2598 (South Africa 2005:s2), a registered nurse will be seen as a person who is able to diagnose a health need, prescribe, provide and execute a nursing regimen to meet the need of a patient or group of patients or where necessary refer a patient to a registered person. In this study the concept "registered nurse" will be used interchangeably with "professional nurse",

1.9 RESEARCH METHODOLOGY

The researcher needs to follow a number of steps when conducting a research study, and select a design that is appropriate to the research focus. The selected research design is described below.

1.9.1 Research design

Du Plooy (2009:85) describes a research design as a plan of how the research is going to be conducted, indicating who or what is involved, as well as where and when the study will take place. In this study, a quantitative research approach, with an exploratory and descriptive design, was applied.

1.9.1.1 Quantitative research approach

Quantitative research refers to a set of decisions regarding what topic is to be studied among what population, with which research methods and for what purpose (De Vos, Strydom, Fouché & Delport 2011:142). The quantitative research approach is concerned about deductive and inductive reasoning, exploratory and descriptive designs, numerical data collection and statistical techniques for data analysis (Du Plooy 2009:93).The following designs are relevant to this study: exploratory and descriptive.

The research study will be conducted in two phases as indicated in Table 1.1.

Table 1.1 Research methodology

Research process	**Compilation of evidence in preparation for meeting the objectives of the study**
Phase 1	Quantitative descriptive study
Approach	Quantitative
Design	Exploratory and descriptive
Population	Nurse managers and registered nurses
Sample	884
Sampling method	Site: simple random sampling for hospitals Population: No sampling was conducted but a census was undertaken
Data collection method	Questionnaire
Assessment of data	Measures to ensure validity and reliability
Data analysis	Descriptive and inferential statistics
Phase 2	Development of guidelines

1.9.1.2 Exploratory design

Exploratory design refers to the research study that is conducted when little is known about the phenomenon that is being studied (Basavanthappa 2007:559). In this study, the exploratory design will be used to determine the level of empowerment, ascertain the effect of powerlessness on the professional conduct and behaviour of nurses and to establish the reasons for lack of empowerment among nurse managers and registered nurses.

1.9.1.3 Descriptive design

Descriptive design refers to the study that is conducted in order to gain more information about characteristics within a particular field of study and to provide a picture of situations as they naturally happen (Grove, Burns & Gray 2013:215). Descriptive designs are used to identify and describe problems within a current practice, justify the current practice, make judgements or determine what other professionals in similar situations are doing (Brink et al 2012:112). This design is relevant to the study because the researcher's aim is to describe the current situation as it appears in the selected hospitals, noting the variables and dimensions affecting empowerment.

The researcher has chosen the quantitative approach as it uses structured procedures and formal instruments to collect information. This approach emphasises objectivity in the collection and analysis of data. It also allows the researcher to analyse data using numerical information through statistical procedures (Brink et al 2012:11).

1.9.2 Validity of the research design

The following section will focus on the validity of the research design of this study.

1.9.2.1 Validity

Validity refers to the measure of the truth or accuracy of a claim. Validity provides a major basis for making decisions about which findings are sufficiently valid to add to the evidence base for practice (Grove et al 2013:197). Internal validity and external validity are noted.

1.9.2.1.1 Internal validity

Internal validity refers to the degree to which changes in the dependent variable (effect) could be attributed to the independent variable (cause) (Brink et al 2012:213). As this study is not experimental in nature, the results of the research should not be affected by extraneous variables that can influence the findings of the study (Brink et al 2012:90).

1.9.2.1.2 External validity

According to Brink et al (2012:212), external validity refers to the degree to which study results can be generalised to other people and other research settings, other than the one studied or respondent samples from the eight (8) selected hospitals that took part in the study. In this study, the research results will not be generalised to other settings that did not take part in the study.

1.9.3 Population

This section will focus on the population. According to Brink et al (2012:131), a population is an entire group of persons or objects that is of interest to the researcher, and is a population that meets the inclusion criteria. The inclusion criteria for this study were that a respondent must be a registered nurse working as a nurse manager or registered nurse in one of the eight public hospitals in the Ehlanzeni District, Mpumalanga.

In this study, the population is divided into a site population and a respondent population.

- **Site population**

The site population consists of the three districts of the Mpumalanga Province with its 28 public hospitals.

- **Respondent population**

The respondent population consists of 884 registered nurses, of which 155 are nurse managers. The two groups of respondents will be discussed in more detail in Chapter 3.

1.9.4 Sampling

According to De Vos et al (2011:223), a sample is a subset of the population considered for actual inclusion in the study. It is the process by which elements are drawn from the population (Fox & Bayat 2007:54).

Sampling refers to the process of selecting representative units of a population for a research study in order to obtain information regarding a phenomenon (Basavanthappa 2007:188). In quantitative research, there are two approaches of sampling namely probability and non-probability sampling. Probability sampling involves random selection of elements. In probability sampling, the researcher can specify the probability that an element of the population will be included in the sample (Polit & Beck 2008:340). Probability sampling includes the following techniques: simple random sampling, systematic random sampling, stratified random sampling and cluster sampling (Brink et al 2012:134).

Non-probability sampling is a process in which a sample is selected from elements or members of a population through non-random methods (Brink et al 2012:215). Non-probability is a sampling approach in which the researcher cannot estimate the probability that each element of the population will be included in the sample (Basavanthappa 2007:562). In this study, probability sampling will be carried out for the hospitals.

The researcher needs to decide on the size of the sample to be included in the study. A sample size refers to the percentage of the population the researcher would want to study (De Vos et al 2011:227). A large sample is important in a quantitative study. The larger the sample, the more representative of the population it is likely to be and the smaller the sampling error is (Polit & Beck 2008:348).

1.9.4.1 Sampling technique

Sampling technique is the means of selecting an element or unit from a population. The sampling technique includes probability or random sampling. Random sampling is a method of drawing a sample of a population so that all possible samples of a fixed size have the same probability of being selected (De Vos et al 2011:226). In this study, sampling is relevant to the site population; the total respondent population was approached to participate, thus seeking to do a census.

- **Site sampling**

Site sampling was conducted by means of simple random sampling. The names of the three districts enclosed within the Mpumalanga Province were placed in a hat and one district was drawn to take part in the study. District 1 was selected, which contains eight public hospitals relevant to this study.

- **Respondent selection**

As the largest number of respondents, within the given population was sought for this study, no respondent sampling was carried out but a census was conducted. The allocation lists of each nursing unit within the eight selected hospitals were used to count the number of nurse managers and registered nurses allocated to each nursing unit. The counting included all nurses who were on day duty, night duty and those who were on leave. The researcher used a census in order to give all nurses the opportunity to participate in the study. A census refers to the counting of all the people in the population (Vasuthevan & Mthembu 2013:61). A census is also defined as a survey covering an entire population. A census includes information about the characteristics of the entire population within a territory (Fox & Bayat 2007:87). This is done in order to enhance the representativeness of the sample (Polit & Beck 2008:340).

1.9.5 Data collection

Data collection refers to the systematic collection of data in the course of a study (Basavanthappa 2007:363). The researcher used one questionnaire for both the nurse managers (Group A) and the registered nurses (Group B) to acquire the explorative and descriptive data in view of their empowerment, or lack thereof.

1.9.6 Data collection instrument

The researcher chose the questionnaire as a data collection method because the researcher wanted to obtain facts and opinions about a phenomenon from people who were informed on the particular issue (De Vos et al 2011:186). A questionnaire is a document containing questions and/or other types of items to solicit information appropriate for analysis (De Vos et al 2011:186). In this study, close-ended and open-

ended questions were used to collect data. Close-ended questions facilitate coding and analysis of data. Even though close-ended questions have disadvantages – such as respondents becoming frustrated with the limited number of responses provided – the researcher still feels that they were the best approach for this study (Brink et al 2012:156).

Open-ended questions were also used. Open-ended questions provided the researcher with more diverse data that could supplement the information gained from closed-ended questions (Brink et al 2012:155).

The researcher developed the questionnaire based on the theoretical framework and the literature review. The questionnaire was made available in English only as all the respondents were registered nurses who had undergone their training in English. Detail concerning the development of the questionnaire will be provided in Chapter 3.

The questionnaire was divided into seven sections A to G:

Section A: Items relating to biographic information of the respondents.

For sections B to F the respondents were required to use a five-point Likert scale.

Section B: Questions relating to empowerment
Section C: Questions relating to structural empowerment
Section D: Questions relating to psychological empowerment
Section E: Questions relating to work behaviours and attitudes
Section F: Questions relating to organisational structure
Section G: Open-ended questions on the empowerment of registered nurses

1.9.7 Validity and reliability of the data collection instrument

The following section will concentrate on the validity and reliability of the measuring instrument.

1.9.7.1 Validity

Validity refers to the ability of an instrument to measure the variable that it is intended to measure (Brink et al 2012:218). There are four common types of instrument validity namely: content, face, criterion, and predictive validity (Brink et al 2012:166). Content validity and face validity are relevant to this study.

Content validity gauges the degree to which the content of a test or survey matches the content it is intended to measure (Vogt 2007:118). This was substantiated by the review of literature. Before the data was collected, the researcher submitted the questionnaire to the statistician, the supervisor and the co-supervisor from the Department of Health Studies at UNISA, two nursing college nurse educators as well as two principals of nursing schools who are also educators and have experience in unit management. The experts were requested to give inputs on the questionnaire; and the changes indicated by experts such as changes in phrasing of certain questions, helped in improving the data collection instrument.

Face validity: Face validity refers to an aspect of validity that examines whether the item on the scale, on the face of it, reads as if it indeed measures what it is supposed to measure (Sekaran & Bougie 2013:396). Face validity also refers to a subjective determination that an instrument is adequate for obtaining the desired information. On the surface, or on the "face" of it, does the instrument appear to be an adequate means of obtaining the desired data? (Brink et al 2012:212). In this study face validity was established by giving the data collection instrument to the experts who evaluated content validity to assess whether the data collection instrument appears to be measuring the appropriate constructs (Polit & Beck 2008:458).

1.9.7.2 Reliability

Reliability refers to the degree to which the instrument can be depended upon to yield consistent results if used repeatedly over time on the same person, or if used by two researchers (Brink et al 2012:169). Item analysis was used to test dimensions in the questionnaire via interpretation of the Cronbach's Alpha Value as a means of establishing the reliability of groups of questions.

1.9.8 Pre-testing of the measurement instrument

The researcher is expected to assess the validity and reliability of the data collection instrument before it could be implemented. This can be done by means of a pilot study or a pre-test. Grove et al (2013:46) state that a pilot study is a smaller version of a proposed study that is conducted to refine the methodology. It can also be conducted to refine an intervention, measurement method, and data collection tool or data collection process, determine whether the sample is representative, examine the reliability and validity of the research instrument, develop or refine data collection and analysis plan. A pre-test of the data collection instrument focuses only on the data collection method and content prior to the administration of a newly developed instrument, aiming to assess the clarity and understanding of questions and to identify problems in terms of comprehension and to determine time requirements for completion (Polit & Beck 2012:7380).

In this study, the researcher chose to do a pre-test. A pre-test was carried out to refine the data-gathering instrument. The researcher pre-tested the questionnaire with ten respondents who were representatives of the target population, but not part of the sample. Ten questionnaires were given to registered nurses to complete. Nine questionnaires were returned.

1.9.9 Data collection process

The researcher personally distributed eight hundred and eighty four (884) questionnaires to the eight hospitals for respondents who met the inclusion criteria. The inclusion criteria for this study were that a respondent must be a registered nurse working as a nurse manager or registered nurse in one of the eight public hospitals in the Ehlanzeni District, Mpumalanga.The researcher provided a sealed container (similar to a tender box) with an opening to allow respondents to drop completed questionnaires into the container. A questionnaire distribution schedule for the different hospitals was implemented to make sure it was an organised and structured process.

In eight of the hospitals the researcher went to each nursing unit to distribute the questionnaires to the respondents and to nurse managers. The researcher did not interfere with the respondents providing nursing care, but was given permission to

communicate with the respondents that were not occupied at the time. After the researcher had explained the information as outlined in the covering letter of Annexure A, the respondents went back to their respective nursing units and completed the questionnaire during their spare time.

The researcher also stressed to all the respondents that all the information would be treated in confidence and would serve no purpose other than for academic reasons, and that they were not to give or sign their names anywhere on the questionnaire. The researcher made the respondents aware that informed consent meant that participation was completely voluntary; and that they could withdraw from the study at any time without incurring any penalty.

The researcher indicated that it would take approximately 30 minutes to complete the questionnaire and they were assured that their names and the names of their hospitals would not be required on the questionnaire. The respondents were requested not to discuss their responses with their colleagues, relatives or friends but to provide the researcher with honest responses reflecting their point of view regarding the empowerment of registered nurses. The respondents were informed about where to drop their completed questionnaires in the sealed containers.

The questionnaires were distributed according to each nursing unit's allocation list. Questionnaires for registered nurses who were on night duty, leave and or sick leave were left with the managers of each nursing unit and the researcher requested the unit managers to distribute the questionnaires when these nurses were available.

1.9.10 Data analysis

After the data has been collected, the researcher is expected to analyse it in order to come up with the results of the study as well as the recommendations. Data analysis refers to the technique by which researchers convert data to a numerical form and subject it to statistical analysis (De Vos et al 2011:249). In this study, descriptive and inferential statistical techniques were applied to analyse the views of the respondents. The assistance of an acknowledged statistician was acquired for the capturing and analysis of data, and numerous discussions took place between the statistician and the researcher to ensure appropriate analysis and correct interpretation of the results.

Seven open-ended questions were included in Section G of the questionnaire. The open-ended questions were analysed and coded by the researcher. All similar responses pertaining to a specific question were grouped and added together. Frequency and percentages were used to quantify the responses with similar information. Thereafter data was interpreted by using the dimensions of Kanter's *Theory of structural empowerment* including 'empowerment' and 'organisational structure' as concepts where applicable.

1.9.10.1 Descriptive statistics

The term "descriptive statistics" refers to the statistical technique and methods designed to reduce sets of data and to make interpretation easier. It includes collection, organising, presentation and analysis of descriptive data (Fox & Bayat 2007:111). It describes what the data shows, while portraying the data in visual representations such as graphs and figures. This approach employs frequency distribution, percentages and measures of central tendency (Brink et al 2012:179). In this study, descriptive statistics were used to analyse the data. "Central tendency" refers to a statistical index of what is "typical" in a set of scores, derived from the centre of the score distribution. The indices of central tendency include the mode, median and mean (Polit & Beck 2012:721). Frequency distribution is a statistical procedure that involves listing all possible measures of a variable and tallying all data on the listing (Grove et al 2013:695). Frequency distribution also includes description of scores in absolute numbers, percentages and proportions (Parahoo 2014:408). In Chapter 4 the descriptive data are presented by means of tables and graphs.

1.9.10.2 Inferential statistical technique

"Inferential statistics" refers to a statistical test that is used to determine if the results found in a sample are representative of a population (Houser 2008:433), and whether they can be inferred to the larger population from which the sample is drawn (Basavanthappa 2007:560). Analysis of variance is a statistical technique used in determining the difference among two groups by comparing the variability between the groups with the variability within the groups (Grove et al 2013:686). Inferential statistics allow inference from sample statistics to a population parameter (Grove et al 2013:697).

In this study, Analysis of Variance (ANOVA) was used to find the difference in comparing tenure for different construct scores.

1.10 ETHICAL PRINCIPLES

There are ethical implications and research principles that the researcher needs to take into consideration at every stage of the research process. The researcher is expected to safeguard the rights of respondents, the institution and the specific study field to ensure the safety of these entities. The researcher is expected to conduct research in an ethical manner from conceptualisation and planning phases, through the implementation phase, to the dissemination phase (Brink et al 2012:32).

The following ethical principles are relevant to this study:

The principle of respect: this principle holds that persons have the right to self-determination and freedom to participate or not to participate (Grove et al 2013:162). The principle of respect also indicates that people have the right to self-determination and to treatment as autonomous agents, meaning that they have the freedom to participate or not to participate in research and people with diminished autonomy need to be protected (LoBiondo-Wood & Haber 2010:250). This principle requires the researcher to inform the prospective participants about the proposed study and to allow them to voluntarily choose whether to participate or not (Grove et al 2013:164).

In this study, the respondents were informed that the researcher would maintain anonymity, participation was voluntary, and that respondents could withdraw their participation from the research study. This information was included in the covering letter that was attached to the questionnaires and the consent form that respondents were requested to complete before they could participate in the research study. During the distribution of the questionnaires to the respondents, the researcher emphasised the following research ethical principles: the principles of respect, beneficence and justice.

The principle of beneficence**:** this principle refers to doing good (Mellish, Oosthuizen & Paton 2010:141). This principle means that the researcher is expected to respect the respondents' decisions, protect them from harm, and to ensure that their well-being is protected (Houser 2008:59). The avoidance of harm refers to *non-maleficence.*

Respondents should not be harmed intentionally through lack of knowledge or negligence (Mellish et al 2010:142). The researcher is expected to prevent risks such as physical and emotional risks, which can occur due to research methods that are experimental or intrusive in nature (Saunders et al 2012:676). Emotional harm includes stress and fear, social harm includes loss of social support and financial harm includes loss of wages (Polit & Beck 2012:152).

The ***principle of justice*****:** This principle refers to the participants' right to fair selection and treatment, meaning that the researcher must select the study population in general with fairness. The researcher should select respondents for reasons directly related to the research problem (Brink et al 2012:36). The principle of justice requires the researcher to prevent injustice, which will occur when a benefit to which a person is entitled is denied without good reason or when a burden is imposed unduly (LoBiondo-Wood & Haber 2010:250). The researcher should acknowledge the participants' privacy. Right to privacy refers to the protection of any data that is provided to the researcher by the participants (Polit & Beck 2008:174). The researcher must ensure that no identifying information is made available to anyone not directly involved in the research (Fox & Bayat 2007:148).

Confidentiality: This refers to the researcher's responsibility to prevent all data gathered during the study from being linked to individual respondents, divulged or made available to any person (Brink et al 2012:38). Confidentiality also refers to a pledge that any information participants provide will not be publicly reported in a manner that identifies them, and the information will not be accessed by friends, and family members (Polit & Beck 2012:723). Names of hospitals will not be used; instead, alphabetical numbering will be used to identify hospitals to ensure confidentiality and the anonymity of respondents.

Anonymity: Anonymity means that respondents will remain anonymous throughout the research, even to the researchers themselves (Fox & Bayat 2007:148). Anonymity also refers to the protection of participants' confidentiality such that even the researcher cannot link individuals with information provided (Polit & Beck 2012:720). The researcher ensured the respondents' anonymity by not requiring their names on the questionnaire (De Vos et al 2011:120). The consent letters signed by the respondents were also kept separately from the questionnaires.

1.11 PERMISSION

The researcher is expected to request written permission from the relevant authorities before conducting a research study. The researcher must submit the research proposal to the ethics committee before beginning the research project (Brink et al 2012:44). Ethical clearance was acquired from the Higher Degrees Committee of the Department of Health Studies at UNISA (Certificate no HSHDC/117/2012) (Annexure C1).

After the ethical clearance was granted, written permission to conduct the study was requested from the Mpumalanga Province Department of Health Ethics Committee (Annexure B1). The research proposal and the questionnaire accompanied the request for permission. Written permission to conduct the study was also requested from nurse managers of the selected hospitals (Annexure B2 − B10).

1.12 STRUCTURE OF THE THESIS

The research report is set out in the following chapters:

Chapter 1 provides the motivation for, and introduction to, the research topic under study. It also provides an explanation of the background to the problem, the problem statement, purpose of the study, objectives, assumptions, theoretical framework, significance of the study, definition of key concepts and planned research methodology.

Chapter 2 serves as the literature review on the theoretical framework, the value of the theoretical framework, Kanter's *Theory of Structural Empowerment* and lastly empowerment. This was achieved by reviewing relevant books, articles, research reports and other sources.

Chapter 3 describes the research methodology. The research methodology deals with the research design, population and sample, data collection, the pre-testing of the measuring instrument and the process of the development of the empowerment guidelines.

Chapter 4 focuses on the analysis of data and discussion of research findings. The discussion includes interpretation of the research results.

Chapter 5 is the final chapter of the investigation. In this chapter, the results of the empirical research are presented. Based on the research findings, conclusions drawn in this chapter are followed by a description of the development of empowerment guidelines in order to enhance empowerment in the workplace.

1.13 CONCLUSION

Empowerment of nurses is important in order to achieve the organisation's goals and to improve quality patient care. The study was conducted in the eight hospitals of the Ehlanzeni District within the Mpumalanga Province.

The purpose of the study was to determine what empowerment encompasses and to establish the reasons for the perceived lack of empowerment of registered nurses. Furthermore, to develop guidelines which managers can apply in order to enhance the empowerment of registered nurses in their service, and in turn cultivate confident nurse leaders. The main sections discussed in this chapter are: background to the problem; problem statement; purpose and objectives of the study; assumption; theoretical framework; significance of the study; definition of key concepts and research methodology consisting of the research design, validity of the research design, population; sampling; data collection; data collection instrument; validity and reliability of the data collection instrument; pre-testing of the measurement instrument; data collection process; data analysis; ethical principles; permission; structure of the thesis and conclusion.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

In this chapter literature relevant to the research topic is reviewed. It encompasses a discussion of the theoretical framework, the value of a theoretical framework, empowerment and how leaders can use empowerment as a tool to develop and motivate their followers in their workplace.

The literature review in this chapter is divided into three sections. The first section provides an overview of the definition of a theoretical framework, and indicates the value of a theoretical framework in a research study. The second section focuses on Kanter's *Theory of Structural Empowerment,* while the last section focuses on explaining empowerment as a concept and process, also noting the influence of organisational structure in empowering employees.

2.2 THEORETICAL FRAMEWORK

In research, a theoretical framework is necessary since it provides a framework on which reasoning – in view of the purpose of a proposed study – can be based (Basavanthappa 2007:107).

2.2.1 Defining theoretical framework

According to Houser (2008:171), a theoretical framework forms the basis for research in a study. It is the basic structure of the idea to be tested in a study. The framework helps the researcher to organise the study and provides a context in which he/she examines a problem and gathers and analyses data (Brink et al 2012:26). A theory is a set of concepts, depositions and propositions that project a systematic view of a phenomenon by designating specific interrelationships among concepts for purposes of describing, explaining, predicting and controlling phenomena (Basavanthappa 2007:104).

2.2.2 The value of a theoretical framework

A theoretical framework clarifies the concepts on which the study is built. It identifies and states the assumptions underlying the study, and specifies the relationship among concepts (Basavanthappa 2007:107). The concepts that form the basis of a study are clarified so that others will be able to understand the study (Basavanthappa 2007:107). The theoretical framework for this study is Kanter's *Theory of Structural Empowerment*.

2.3 KANTER'S THEORY OF STRUCTURAL EMPOWERMENT

Empowerment of nurses in various forms equips them to perform their responsibilities in a manner that positively affects their service delivery to patients. In this study, Kanter's *Theory of Structural Empowerment* will be used to focus on the empowerment of registered nurses. The *Theory of Structural Empowerment* was developed by Rosabeth Moss Kanter. She believes that access to empowerment structures is enhanced by specific job characteristics and interpersonal relationships that foster effective communication (Laschinger et al 2009:229).

Managers in charge of clinical practices should ensure that the following job characteristics are available to facilitate the empowerment of employees in the workplace. The job characteristics include autonomy, required interaction, optional interactions, knowledge and required skills. In clinical practice, an employee who has a high need for autonomy would perceive involvement in decision-making differently than an employee who has a low need for autonomy (Ivancevich et al 2008:160).

Kanter's *Theory of Structural Empowerment* emphasises the importance of giving power to employees in order for them to accomplish their tasks (Lucas et al 2008:965). Power is viewed as having the ability to create, get, and use resources to achieve one's goals (Kelly 2008:689). Power is necessary in order to be able to influence an individual or group. Nurses need power to influence patients, physicians, and other health care professionals, as well as each other. Powerless nurses are ineffective and less satisfied with their jobs (Manojilovich 2007:2).

According to Lucas et al (2008:965), Kanter's *Theory of Structural Empowerment* is divided into three components. Component one is concerned with *structural empowerment*, which includes the dimensions of opportunity, information, support, resources, formal power and informal power. Component two is concerned with *psychological empowerment,* which includes meaning, confidence, autonomy and impact as sub-components. Component three is concerned with *positive work behaviours and attitudes* and includes job satisfaction, commitment, low stress and low burnout as dimensions.

Manojlovich (2007:3) states that empowerment arises from social structures in the workplace, which enable employees to be satisfied and more effective on the job. Organisations need to have empowerment strategies in place before employees can feel empowered. These empowerment strategies include participative management, job enrichment, meaningful organisational goals, less bureaucracy, and involving staff in decision-making (Manojlovich 2007:6). Managers in charge of wards/units can facilitate empowerment of nurses by delegating assignments to provide learning opportunities for less experienced staff, for example delegating a registered nurse to assist a doctor during the doctor's ward rounds based on the scope of practice of the nurse (Marquis & Huston 2012:288).

Table 2.1 indicates the key components of Kanter's *Theory of Structural Empowerment* that will be discussed in depth in the following section.

Table 2.1 Key components of Kanter's *Theory of Structural Empowerment*

Structural empowerment	**Psychological empowerment**	**Positive work behaviours and attitudes**
Opportunity	Meaning	Job satisfaction
Information	Confidence	Commitment
Support	Autonomy	Low stress
Resources	Impact	Low burnout
Formal power		
Informal power		

The study deals with empowerment of registered nurses in the workplace. Kanter's *Theory of Structural Empowerment* contains 14 dimensions under the three key

components as illustrated in Table 2.1; it does not include a dimension on 'empowerment' as such.

Kanter's Theory deals with empowerment, but this concept is not included as one of the dimensions of this theory. It must however be reviewed in the literature and be tested by means of the data collection instrument. Attention will be given to empowerment in the literature review after the discussion of Kanter's Theory has been concluded, and it is included in the questionnaire under section B.

2.3.1 Structural empowerment

Generally, an organisation needs to have empowering structures in place to facilitate achievement of its organisational goals. Without these structures, it might not be possible for the organisation to meet the needs of its customers. This section includes the discussion of each aspect of Kanter's *Theory of Structural Empowerment.* Williamson (2007:133) conducted a study on nurses' perceptions of empowerment, the study suggests that empowerment is linked to autonomy, job satisfaction, retention, power, professional growth and development. This study further indicates that nurse managers have the responsibility of structuring work environments, so that they promote the empowerment of nurses. For example, in the wards/units the nurse manager can practise shared governance by involving registered nurses in participative decision-making, especially when taking decisions that are related to patient care (Williamson 2007:142).

In this section, *structural empowerment* will be discussed based on the following sub-topics/dimensions: opportunity, information, support, resources, formal and informal power.

2.3.1.1 Opportunity

According to the *Longman Dictionary of Contemporary English for Advanced Learners* (2009:1226), opportunity refers to a chance to do something, or it could be an occasion when it is easy for a particular person to do something. Quick and Nelson (2013:4) indicate that opportunity refers to favourable times or chances for progress or advancement in an organisation. According to Quick and Nelson (2013:367),

opportunity also means participating in decision-making in the form of choice, for example, allowing employees to make off duty requests to their supervisors which offers employees the opportunity to have a voice in the compilation of ward/unit off duties. Orgmbidez-Ramos and Borrego-Ales (2014:30) view opportunity as referring to the possibility for growth and movement within the organisation as well as the opportunity to increase knowledge and skills. Organisations need to be sensitive and responsive to changes, for example, managers need to create opportunities for nurses in order to train them on how to use the new technology by providing training for basic computer skills and on how to access the internet to improve quality patient care.

Managers can facilitate the empowerment of nurses by letting those closest to the situation make decisions regarding the area of their responsibilities and create opportunities for employees to perform their duties (Marriner-Tomey 2009:125). An opportunity to perform refers to the absence of obstacles that constrain the employee (Robbins et al 2010:180). Managers can enhance the opportunity to perform by coaching subordinates in clinical practice by the clarification of goals and by providing guidance during the provision of patient care when an employee is uncertain about how to carry out a certain nursing procedure (Roussel 2013:666), for example checking a patient's blood pressure, thus removing obstacles to satisfactory performance.

Nurse managers should create opportunities for employees to learn new skills and perform challenging tasks (Ivancevich et al 2014:114). An opportunity represents a situation in which there are possibilities to do things that lead to results that exceed goals and expectations of delegated responsibilities (Kinicki & Fugate 2012:253)**.** Employees lacking opportunities feel stuck in their jobs, and have low job expectations and organisational commitment (Lucas et al 2008:965).

Other opportunities that managers could make available to their employees are access to challenges, rewards, and professional development such as allowing nurses to attend job-related seminars and workshops**.** Ning, Zhong, Libo and Qiujie (2009:2643) suggest that ways to increase their clinical practice knowledge and skills are through participation on committees, task forces and interdepartmental work groups that give them an opportunity to work with people in other areas of the organisation. The opportunity to perform is enabled by a working climate which provides the necessary support so that employees can achieve their full potential. This support should pertain to

both the formal and informal structures of the organisation and include factors such as the quality of resources and the availability of channels for influencing management decisions (Wilton 2011:50).

Managers of organisations should ensure that the *Skills Development Act no 97 of 1998* is implemented in order to create opportunities for the development of employees. Skills development in the workplace plays a major role in improving the quality of life of workers, it facilitates an active learning environment, and helps in assisting employees with the opportunity to acquire new skills that are necessary for the achievement of the organisation's goals (South Africa1998:26).

Application to Kanter's Theory

Orgmbidez-Ramos and Borrego-Ales (2014:30), view opportunity as referring to the possibility for growth and movement within the organisation as well as the opportunity to increase knowledge and skills. The definition of Orgmbidez-Ramos and Borrego-Ales (2014:30), indicates that managers should create opportunities for empowering employees to develop and grow in the workplace by creating a working climate that supports employees to increase knowledge and skills, and by involving employees in decision-making related to their jobs to allow them to reach their full potential in meeting organisational goals (Wilton 2011:50). The creation of opportunities for employees in the workplace is in line with Kanter's Theory which indicates that access to opportunities means enabling employees to learn and grow in their jobs and to participate in decision-making so that they do not feel stuck in their jobs (Lucas et al 2008:965).

2.3.1.2 Information

According to the *Longman Dictionary of Contemporary English for Advanced Learners* (2009:903), information can be facts or details that tell someone something about a situation, person, or event. Lucas et al (2008:965) state that information refers to having informal and formal knowledge that is needed to be productive in the workplace, not only technical knowledge, but also an understanding of the organisation's processes. Information is power and comes from knowledge. It is a source of power when others need the information (Marriner-Tomey 2009:120). Leaders should not hoard information, but should impart information and help to empower future leaders to learn

(Ulrich & Smallwood 2007:191). For example in clinical practice nurse managers are expected to share information such as protocols, policies, their experiences, expertise and job descriptions with employees in order to provide them with information which could enable and enhance performance.

A job description is a summary statement of what an employee does on the job (Ivancevich 2014:553). The information in job descriptions should be specific and relevant rather than being vague and should avoid generalisation (Marriner-Tomey 2009:346).

According to Marriner-Tomey (2009:228), policies and procedures are means to accomplishing goals and objectives and serve as guides that define the general course and scope of activities that help to accomplish organisational goals. Marriner-Tomey (2009:230) states that information related to policy statements should be communicated to all nurses verbally, by letters, bulletin boards, incident reports, policy manuals and meetings to explain new policies to personnel affected by the policies (Meyer et al 2009:269). Marquis and Huston (2012:425) indicate that information should flow downward, upward, horizontally and diagonally to ensure that all employees receive the required information related to their work.

For example, in clinical practice the ward/unit nurse managers give information to employees related to their performance through feedback. Feedback refers to the degree to which carrying out the work activities required by a job results in the individual obtaining direct and clear information about the effectiveness of their performance (Robbins, Judge & Campbell 2010:174). Quick and Nelson (2013:736) state that feedback refers to information exchange, which completes a two-way communication process. Employees do better when they get feedback on how well they are progressing toward their goals because feedback helps to identify discrepancies between what they have achieved and what was expected; feedback therefore guides behaviour (Robbins et al 2010:149). Feedback should be given regularly such as daily or weekly to produce more consistent effects and to facilitate carrying out of delegated duties (Roussel 2013:665). Feedback also determines whether understanding has been achieved or not (Robbins et al 2010:290).

Nurse managers need to obtain information from colleagues, subordinates and department heads, and from outside stakeholders in order to make sound job-related decisions (Smit et al 2011:14). Participative decision-making should be practised by nurse managers by involving all the staff affected by a decision, by giving staff the opportunity to voice their opinion or give input on issues related to their jobs, and by treating all staff involved equally in the decision-making process (Meyer et al 2009:240). Members who want to contribute to decision-making need sufficient information in order to make good decisions; even those members who do not want to contribute to decision-making still need to have information about the organisation beyond their tasks, as information may include job-related knowledge and skills that are compulsory and important for their performance (Abraiz, Tabassum, Raja & Jawad 2012:394). Organisations should ensure that nurses have access to the internet so that they can access accurate and up-to-date information which they need to carry out their work, and to ensure that quality care is provided to patients (Kelly 2008:144).

Application to Kanter's Theory

The possession of information means knowing the formal and informal happenings in the organisation (Gilbert et al 2010:340). The provision of information to employees is supported by Kanter's Theory which indicates that access to information enables employees to be productive, to understand organisational processes and to access correct sources that could provide them with relevant information to make appropriate work-related decisions (Lucas et al 2008:965). In clinical practice managers should empower employees by providing employees with the relevant protocols, policies, work procedures and job descriptions as sources of information that employees could utilise to carry out their delegated responsibilities in their nursing units (Meyer et al 2009:268).

2.3.1.3 Support

Lucas et al (2008:965) define support as receiving feedback and guidance from sponsors, peers and subordinates. Support encourages original thinking, risk-taking behaviour and autonomous decision-making. Wagner et al (2010:449) support the views of Lucas et al (2008:965) but indicate that support is also available in the form of feedback and guidance received from superiors, peers and subordinates. Jooste (2011:407) views support as the degree to which employees believe the organisation

values their contribution and cares about their well-being and personal needs for instance when an employee has a child or transport problem (Robbins et al 2010:64). The manager can show support in the nursing unit by listening to the needs of staff, assist in problem-solving and by encouraging reflection and self-awareness (Jooste 2011:407). When managers support employees they promote cooperation by giving timely and specific feedback, acknowledging the employees' viewpoints and needs and recognising their efforts and accomplishments (Marriner-Tomey 2009:6).

Sullivan (2013:258) proposes that managers should ask employees for suggestions, allow employees to use their analytic skills to solve their own work-related problems, and they should also listen openly in order to understand the employees' perspective. In clinical practice managers are expected to delegate responsibilities to subordinates. The manager should be supportive of delegated tasks by giving a clear description of what it is that an employee is expected to do and describe the overall scope and background of the current task in order to enable the subordinate to carry out the delegated task (Grohar-Murray & Langan 2011:175). Supporting employees also focuses on subordinates' needs and well-being and on promoting a friendly work climate (Schermerhorn et al 2012:300).

Managers can facilitate support in their organisations by developing supportive networks. Support networks provide strength and promote sharing of problems and ways of improving the organisation's outcomes (Whitehead, Weiss & Tappen 2007:223). Affiliation to groups provides an opportunity for people to network with others both inside and outside their own social groups and allows them to become empowered (Bhengu 2010:10). Generally, in practice, registered nurses can network with other registered nurses by affiliating to professional organisations, such as the Democratic Nursing Organisation of South Africa (DENOSA).

This body (DENOSA) informs nurses about conferences and workshops, for example in the *Nursing Update* of September 2015 a conference scheduled to take place in February 2016 is advertised. During conferences and workshops registered nurses are able to network and share knowledge and skills that are necessary for clinical practice. Supervisors can also support employees by giving hands-on assistance where nurses are faced with challenging health needs of patients. This is an indication that the supervisor is willing to guide and support (Ning et al 2009:2643).

Application to Kanter's Theory

According to Lucas et al (2008:965), support refers to receiving feedback and guidance from sponsors, peers and subordinates. Support includes giving a clear description of the work to be carried out by an employee on delegated duties (Grohar-Murray & Langan 2011:175), as well as giving hands-on assistance to employees during the execution of their duties to empower them in the workplace (Ning et al 2009:2643). The giving of support to employees is in line with Kanter's Theory which postulates that access to support includes receiving feedback and guidance from sponsors, peers and subordinates (Lucas et al 2008:965). Feedback by supervisors enhances the empowerment of employees in the workplace (Faulkner et al 2008:215).

2.3.1.4 Resources

The term 'resources' refers to money, property and skills that are available for use when they are needed *(Longman Dictionary of Contemporary English for Advanced Learners* 2009:1487*).* Organisations need resources in order to achieve their goals. Managers have the responsibility of bringing resources together and deciding which resources are needed in order to achieve the organisation's mission and goals**;** and managers are also responsible for the success and sustainability of their organisations (Smit et al 2011:4). Organisational resources are divided into financial resources (money), physical resources (raw material), equipment and supplies, technology and human resources (Smit et al 2011:4).

Apart from management's responsibility to ensure that adequate and sufficient resources of all kinds are available for organisational functioning, the availability or lack of resources has a definite effect on the ease with which employees or practitioners perform their duties. Seeking to deliver quality patient care without the necessary resources leads to frustration and a sense of helplessness in reaching one's patient care objectives.

2.3.1.4.1 Financial resources

The term ‘finances’, refers to money (*Longman Dictionary of Contemporary English for Advanced Learners* 2009:643). Managers of institutions need to ensure that they have all the required resources in sufficient quantities in place in order to be able to carry out the plans to achieve their organisation’s goals, but this can only be achieved if they budget for resources and acquire the necessary funding (Smit et al 2011:142). A budget is a detailed financial plan for carrying out the activities of an organisation or unit (Motacki & Burke 2011:169). In clinical practice it is important for nurse managers to involve employees when drawing up the institution’s nursing budget. Nurse managers can obtain suggestions or inputs from subordinates who do the functional work, the doctors involved, as well as from other team members such as the pharmacists and technicians. This will help the nurse manager to be aware of the needs of units and departments (Jooste 2011:392). The major types of budgets that organisations use include an operating budget, a capital expenditure budget and cash budget (Yoder-Wise 2007:230).

Operating budget: An operating budget is the financial plan for the day-to-day activities of the organisation. The operating budget consists of a personnel budget and a supply and expense budget for each cost centre. The organisational unit that allows costs to be identified and managed is known as a cost centre (Yoder-Wise 2007:230). This budget applies to and makes provision for developmental opportunities, information technology and all forms of resources which are important components of structural empowerment as the availability of these aspects, or the lack thereof, has a direct influence on the ease with which staff members perform their duties and the satisfaction they may experience in the work environment.

Capital expenditure budget*:* A capital expenditure budget reflects expenses related to the purchase of major capital items such as equipment. Items on this budget should have a useful lifespan of more than one year and must not exceed a cost level specified by the organisation (Yoder-Wise 2007:232). A capital expenditure budget includes land and fixed and movable items (Muller et al 2011:451).

Cash budget: A cash budget is a month-to-month plan of cash expenditures and receipts (Muller et al 2011:451). A cash budget helps in locating cash received and spent (Motacki & Burke 2011:169).

Generally, in clinical areas, nurse managers and unit managers need to ensure that wards/units have detailed financial plans stipulating how each unit will carry out its activities in order to achieve the unit and organisational goals. However, it is known that in general, nurses are not confident when it comes to financial management. This is supported by Brannagan (2012:79) who indicates that many healthcare organisations still feel that nurse managers lack financial skills. Therefore the expectation and perceived need that nurses should acquire financial skills, could be beneficial to empowering nurses in terms of such an important management task as financial management.

Having acquired these skills nurses would be able to be more autonomous in their management role and have a greater impact on their delivery in terms of cost- effective management, monitoring and evaluation and proactive planning. This may be achieved through in-service education or assignments, where nurses are taught the budgeting process, are shown and guided to develop unit and departmental budgets by negotiating and revising inputs, and where they are taught which information they require for monitoring and evaluating expenditure (Yoder-Wise 2007:233).

Nurse managers need to familiarise nurses with the acts that deal with financial management. Muller et al (2011:439) state that *The Public Finance Management Act, 1999 (Act 1 of 1999)* and the *Finance Act, 2008 (Act 42 of 2008),* were put in place with the aim of enhancing organisational transparency, accountability and sound management of revenue. Nurse managers, ward/unit managers and the organisational finance committee should possess financial management skills to ensure establishing and sustaining the appropriate financial management systems, policies and procedures/processes to accommodate the organisational, legal and ethical (corporate governance) requirements in accordance with the type of business ownership. They should also ensure timely execution of the financial management principles and processes (budgeting and expenditure control) in accordance with the organisational, legal, professional-ethical and corporate governance requirements; and that money is spent in relation to the budget for the defined output and service delivery. They should

have the know-how to see to the continuous evaluation of the most cost-effective forms of delivery and improvement of efficiency and resource utilisation and should be able to make financial decisions (Muller et al 2011:443).

Organisations have the responsibility to put in place financial control measures. They can use the process known as budgetary control. Budgetary control indicates how funds are allocated for different activities, departments or sections in an organisation. This could be done by means of financial analysis which reflects the organisation's total performance in the achievement of its missions and goals (Smit et al 2011:450).

2.3.1.4.2 Physical resources (raw material)

According to Smit et al (2011:445), an organisation's physical resources are its tangible assets, such as buildings, office equipment and furniture, vehicles, manufacturing machinery and equipment, and raw materials. Nursing units also need office supplies, equipment, rental fees, maintenance costs, and equipment service contracts (Sullivan 2013:192).

In clinical areas, registered nurses, and ward/unit managers in general have the responsibility to ensure that physical resource control measures are implemented by means of asset registers, periodic inspections and stocktaking. Asset control can be maintained by inventory control measures. This includes control of reserves of resources held in readiness to produce products and services as well as the end products that are kept in stock to satisfy consumers and customers' needs (Smit et al 2011:445).

2.3.1.4.3 Technology

Technology refers to new ways of doing things that are based on modern knowledge about science and technology (*Longman Dictionary of Contemporary English* 2009:1811). Information technology provides ways through which employees could access information. These include corporate intranets, extranets, the internet, video conferencing, collaborative computing, voicemail, e-mail and voice conferencing Bagraim, Cunningham, Pieterse-Landman, Potgieter and Viedge (2011:22). Health organisations need clinical decision-support tools and information systems to keep up-

to-date on improving patient care (Finkelman (2012:496). The easy access to information through technology, the wide scope of available information and the user-friendly instruments through which information can be acquired – all contribute to the knowledge and confidence of nurses as they enable them to deal with uncertainties, gain required information and enhance their understanding of a matter.

Three types of technology commonly used by nurses are:

- ***Biomedical technology***, which involves the use of equipment in clinical settings for diagnosis, physiological monitoring and administration of therapies to patients (Yoder-Wise 2007:195). An example is the use of telemedicine which allows medicine to be practised from a distance, when the doctor is not at the bedside of the patient. Through telemedicine the doctor can monitor the patient's blood pressure and heart rate and prescribe medication. The use of telemedicine improves communication between the nurse practitioner and the doctor, thus improving access to health care.

- ***Information technology,*** which is concerned with recording, processing, and using data and information with the aim of delivering patient care (Yoder-Wise 2007:195). Information technology gives health care providers the opportunity to track patient information across health care settings anywhere in the world, and to analyse the data effectively (Finkelman 2012:507). Having access to information technology and having the skill to use it effectively augments the practitioner's confidence and competence in information management and distribution.

- ***Knowledge technology***, which makes use of experts and decision-support systems to assist nurses in making decisions about patient care. The decision-support systems assist with decision-making for novices and nurses working outside their areas of expertise and assist with the validation of decisions (Yoder-Wise 2007:206). For example, a nurse practitioner working at a clinic can communicate with a gynaecologist when encountering a problem with a patient that is presenting with a threatening abortion. The sharing of information and expertise, and receiving support from the specialist facilitate the empowerment of the nurse through structural empowerment.

To facilitate empowerment, managers should be trained to link employees to resources within and outside the organisation through professional networking with other professions such as doctors and pharmacists and with other nurses from other institutions in order to share information, knowledge and skills. Employees should be assisted to interact with their fellow employees and managers throughout the organisation. One effective way of doing this is by means of e-mails and electronic memos and circulars. Not only does it reach all staff members who have access to computers, but it ensures that everybody receives the same written information. Employees must also be trained to understand how to use e-mail and other electronic tools for communicating, and how to collect and share information (Noe 2008:13).

The use of technology in nursing practice emphasises the need for nurses to be trained in using the electronic hardware and relevant software in order to be able to use the new methods and techniques of providing services. Nurse managers are expected to ensure that training programmes are made available to employees for broad-based skills and job-specific technology training (Grobler et al 2011:28).

2.3.1.4.4 Human resource or human capital management

The human resources section in a company refers to the department that deals with employing, training, and helping people *(Longman Dictionary of Contemporary English for Advanced Learners* 2009:859*).* Muller et al (2011:244) note that human resource or human capital refers to the traits that people bring to the workplace, their intelligence, aptitudes, commitment, tacit knowledge and skills, and their ability to learn.

In spite of their acquired skills, people's behaviour may be contrary and influenced by several factors, such as ability, motivation, role perception, situational contingencies, control and commitment. Bagraim et al (2011:20) state that human capital management refers to the process of acquiring, developing, deploying and retaining the collective knowledge, skills and abilities of employees by utilising systems and processes that integrate or match employee talent with overall business goals. Human resource management also includes finding the right people for the job and ensuring fair remuneration/ compensation for each worker. This is achieved by recruiting candidates and selecting the best one for the job and appointing that person (Smit et al 2011:13).

Well placed employees usually function effectively; use the available opportunities to grow and develop and build their expertise in an area/discipline of interest, thereby enhancing their confidence, competence and autonomy which are dimensions of psychological empowerment.

2.3.1.4.5 Human resources management functions

In an organisation the function of the human resource department is to recruit, hire, promote, transfer, and terminate employees according to the organisation's policies, procedures and relevant laws (Finkelman 2012:272). According to Smit et al (2011:6), this is achieved by individuals who have to perform management functions, such as planning, organising, leading and controlling in terms of human resources, in such a way as to enable the organisation to reach its mission and goals as productively as possible. According to Muller et al (2011:246), the functions of the human resource department include planning and provision of human resources; maintenance; utilisation; assessment and development of human resources; and fair labour practices. Grohar-Murray and Langan (2011:273) state that the staffing needs differ from department to department, for example in the operating theatre unit more staff may be required during operation days. When doing staffing, nurse managers should be cognisant of the diverse patient needs, and the appropriate number and skill mix of nursing resources required meeting the workload demand for nursing care at the unit or department level in order to enable employees to provide quality patient care to patients. *Skill mix* refers to the type, number, and ratio of staff necessary to perform the established work; this should include the optimum ratio of registered nurses licensed or certified to support personnel for a particular unit of patient service. In considering human resources as a component of structural empowerment, the required or ideal skill mix, in honouring the different scopes of practice, is often not possible due to staff shortages or the financial restraints of an organisation. Thus staffing of specific units is not always conducive to optimal patient care and may cause senior nursing staff to be concerned and anxious about the quality of care received by the patients.

Nurse managers are expected to plan and to manage human resources and unit activities to ensure that time is not wasted. For example if meetings are due, the nursing unit manager should ensure that meetings are planned and should start on time. Nursing unit managers should ensure that time is allocated for meetings, for example

meetings should be limited to 50 to 90 minutes. Meetings that exceed 90 minutes should be planned to include breaks at least every hour (Sullivan 2013:155).

2.3.1.4.5.1 Planning and provision of human resources

Human resource planning is the process of anticipating and making provision for the movement of people into and out of the organisation with the purpose of deploying the resources effectively when and where they are needed (Muller et al 2011:254). Planning and provision of human resources include job analysis, job evaluation, recruitment, selection and appointment.

Job analysis is a systematic way of gathering and analysing information about the content, context and the human requirements of a job (Grobler, Warnich, Carrell, Elbert & Hatfield 2011:664). Job analysis refers to the group of techniques which is used to determine the content of the job (job description) and the knowledge, skills and abilities that job holders need to carry out the required tasks (Muller et al 2011:242). The job description lays out the job expectations to be used for hiring and performance evaluation (Finkelman 2012:277). According to Grobler et al (2011:159), job analysis may be required in the following situations:

- Organisational restructuring due to downsizing, which calls for basic changes in who does what, where and with what?
- The need to motivate and reward people on the basis of what they know and the complexity of their jobs.
- Adjusting to the impact of technology, such as information systems technology.
- Adhering to labour legislation pertaining to employment and general disciplinary practices.

Muller et al (2011:263) state that when conducting job analysis, nurse managers should focus on the following two stages:

The first stage involves data collection. Data collection includes three tasks: identifying the job to be analysed; developing a job analysis questionnaire; and collecting the data by means of a questionnaire (Muller et al 2011:263).

The second stage is the application of the collected information by preparing job descriptions, job specifications and job standards (Muller et al 2011:263). Each organisation should have a job analysis committee. The committee should consist of representatives from labour unions, all the major departments in the organisation to be studied, and from the professional bodies of which employees are members. Nurse managers should also consult employees and give them the opportunity to submit inputs to their supervisors about the analysis of a job (Grobler et al 2011:159).

Job evaluation refers to that part of a compensation system in which a company determines the relative value of one job in relation to another (Grobler et al 2011:167). Job evaluation is concerned with the systematic, rational assessment of jobs to determine their internal worth; it does not evaluate the incumbent of a specific job. Job evaluation should meet the following requirements:

- Provide a consistent measure of job worth that is easily understood by everyone concerned.
- Involve managers from its inception through its administration and subsequent revision.
- Protect employees from favouritism, bias and resultant internal pay inequities.
- Measure the job and not the performance of employees doing the job.
- Apply to broad clusters in a functional group (Muller et al 2011:267).

Recruitment refers to the process of acquiring applicants who are available and qualified to fill positions in the organisation (Grobler et al 2011:666). Organisations can recruit internally or externally. Internal recruitment provides current employees with an opportunity (*structural empowerment*) for advancement and may increase the morale of employees and it is also less expensive, but it can lead to unhealthy competition amongst employees, thus lowering the morale of those who were not promoted. External recruitment reduces internal fighting but it destroys the incentive of employees to strive for promotion (Grobler et al 2011:183).

Selection refers to the process of choosing individuals who have the relevant qualifications to fill existing or projected job openings (Muller et al 2011:568). Selection involves verifying the applicant's qualifications, checking his/her work history, and

deciding if a good match exists between the applicant's qualifications experience and personally and the organisation's expectations (Marquis & Huston 2012:340).

In employing staff, employers should implement the *Employment Equity Act 1998 (Act 55 of 1998)* when recruiting and selecting employees. This act protects people with disabilities against unfair discrimination and entitles them to affirmative action measures (South Africa 1998:7). When recruiting employees, the employer should clearly describe the necessary skills and capabilities of the job and set reasonable criteria for selection. The advertisement should include sufficient detail about the essential functions and duties of the job so that the new appointee could successfully add to the human resource capabilities of the organisation, which would strengthen structural empowerment.

2.3.1.4.5.2 Maintenance of human resources

Maintenance of human resources refers to the creation of a safe workplace environment that is both pleasant and safe for all employees (Muller et al 2011:286). It is therefore the responsibility of managers to establish wellness programmes, such as providing employees with check-ups for cholesterol and blood pressure, weight and nutritional education, and encourage employees to take part in the programmes to keep them healthy (Grobler et al 2011:27). In this way, employees experience a measure of support from their employer which could lower stress and prevent burnout. Organisations are obliged to implement the *Occupational Health and Safety Act, 1993 (Act 85 of 1993)* as all role players in an organisation should ensure that the work environment is safe and healthy. Role players include management, the employee, safety representatives, safety committees and inspectors. All these people play a role in the achievement and maintenance of a safe and healthy work environment (Muller et al 2011:288) and it requires commitment from all.

The *Occupational Health and Safety Act 1993 (Act 85 of 1993),* lays down certain rules aimed at preventing accidents at work (Grobler et al 2011:468).

It lays down the rules for the protection of the health and safety of workers at work by the organisation (Clarke 2014:274). The act is concerned with the provision of a safe work environment and the protection and promotion of the health of all employees. The

duties of the employer in the workplace include eliminating hazards; providing information on the nature of the materials that they are expected to use when performing their duties, respecting the dignity of each employee at all times, establishing health and safety committees in terms of the *Occupational Health and Safety Act* and informing management and employees about the functions of these committees (Clarke 2014:278).

The duties of the employees include commitment to the care of their own health and safety; as well as that of others who might be affected by their actions; complying with the rules and procedures that the employer gives; and to report unsafe or unhealthy conditions to the employer or health and safety representative (Grobler et al 2011:469). Human resource maintenance looks at the protection of staff against discrimination and unfair labour practice, therefore nurse managers should ensure that employees' rights are protected in the workplace. Grobler et al (2011:494), state that the *Labour Relations Act 66 (Act no 66 of 1995)* allows employees to join unions and participate in their activities; they can picket in support of a protected strike or against any lockout, and join decision-making on various proposals if there is a workplace forum. This act also gives employers certain rights, namely to join employers' organisations and participate in their activities; and to lock out workers; keeping in mind the possibility of successful restructuring of the workplace through information sharing and consultation. In terms of empowerment, this act aims at providing fair training and development opportunities, as well as sufficient information and resources for employees to function effectively. According to Bezuidenhout, Garbers and Potgieter (2007:108), training and retraining are critical to organisations because they provide the skills needed both now and for the future.

2.3.1.4.5.3 Utilisation of human resources

Staffing refers to the function of planning for hiring and deploying qualified personnel to meet the needs of patients for care and services (Yoder-Wise 2007:610). Nurse managers need to identify the nursing staffing needs of the organisation and that of the different wards and units. Staffing needs focus on the patient census; the patient care delivery system that is in place; the education and knowledge level of required staff; budget constraints; the diversity of the population to be served and peak staff resignation periods (Marquis & Huston 2012:325). An organisation needs to acquire

staff, screen, interview and select appropriate staff for the different vacancies (Finkelman 2012:276) in order to be able to staff nursing units with sufficient, adequately trained personnel in accordance with the recommended skills mix to support structural empowerment.

According to Muller et al (2011:327), managers have the responsibility of checking the following in connection with staffing:

- **The number of patients** (a census). Patient census includes the number of patients to be cared for in a given shift. A change in patient population could increase the nursing workload. Nursing service managers are required to ensure that there is no understaffing or overstaffing.
- **Patient acuity classification:** This involves the calculation of the total number of patients to be cared for and their category of care needs, which could be self-care, minimal care, full care or intensive care. This is done in order to determine the required nursing hours in line with patient needs.
- **Skill mix of staff:** Skills mixing allows the nurse manager to select the best-equipped category of nursing staff to care for a particular patient or group of patients.
- **Nursing care delivery system:** Nurse managers should specify and decide on the method of personnel assignment to be used in each unit. The type of nursing care delivery system determines the number of nurses required from the different categories of patient care. Nurse managers can utilise any of the following methods: functional nursing, team nursing, case method, and case management method.

Managing employees requires that nurse managers take into consideration the *Basic Conditions of Employment Act 77 (Act 75 of 1997)*. Chapter 2 of this act requires the employer to regulate the working time of each employee. This includes the ordinary hours of work, overtime, and averaging of hours of work (South Africa 1997:14). Other aspects that managers need to consider are stipulated in Chapter 4 of the *Basic Conditions of Employment Act 77 (Act 75 of 1997)*. These aspects include payment of remuneration, deductions from employees' salaries and keeping of records (South Africa 1997:30).

Communication plays an important role in an organisation. Communication refers to a complex, ongoing, dynamic process in which the participants simultaneously create shared meaning in an interaction (Sullivan 2013:341). Nurse managers use communication to share thoughts, attitudes, information and feelings with their subordinates and among themselves (Finkelman 2012:378). Managers and supervisors use communication as a means to inform subordinates about the organisational events, as well as informing them about policies that affect them. They communicate and interact with their subordinates regarding work allocation and problem-solving; with statutory bodies who regulate the scope of practice of health care practitioners; and with organised labour who often participate and give input in the development of human resource related policies (Muller et al 2011:315). Communication thus supports the sharing of information which is a dimension of structural empowerment, and through communication support is given or transferred.

2.3.1.4.5.4 Assessment and development of human resources

Assessment is a process by which the characteristics and needs of clients, groups or situations are evaluated or determined. Assessment forms the basis of a plan for services or action (Muller et al 2011:549). Development refers to the managerial function of preserving and enhancing employees' competence in their jobs by improving their knowledge, skills and abilities (Grobler et al 2011:662), as has been noted earlier in the chapter. Personnel development can best be planned and implemented if the training and development needs have been identified, and this usually takes place during the performance appraisal process.

- *Performance appraisal and management*

Organisations have the responsibility to ensure that employees are appraised according to performance standards. Performance appraisal is the process that is used in an organisation by which the employee is routinely evaluated according to performance standards (Motacki & Burke 2011:191). Performance appraisal is also viewed as the process of observing and evaluating an employee's performance, recording the assessment, and providing feedback to the employee (Muller et al 2011:564). Performance appraisal can be either formal or informal. The formal appraisal involves written documentation according to specific organisational guidelines. An informal

appraisal may involve praising the individual for recognised performance at any point in time. For example, specific bulletin boards can be utilised to place thank you notes from patients or from the ward/unit manager (Yoder-Wise 2007:295). Performance appraisal gives the supervisor an opportunity to provide feedback, direction, and leadership; time to show support and encouragement; time to initiate a discussion about areas that need improvement; an opportunity to evaluate accomplishment and to set goals (Finkelman 2012:289).

Managers use performance appraisal to manage the performance of employees. Individual performance management focuses on measuring, monitoring and evaluating performance that is followed by initiating steps to improve performance where the supervisor has identified developmental needs (Muller et al 2011:353). Feedback allows the supervisor to discuss the consequences of performance and to redirect the efforts of the employee should it be necessary, it also allows employees to improve their performance by having their deficits pointed out (Bagraim et al 2011:126). Positive feedback, coaching, achievement recognition and support for new ideas, enhance employees' feelings of empowerment and their ability to perform effectively, thus reducing stress levels and building commitment to their task responsibilities (*positive work behaviours and attitudes*).

Supervisors can enhance the empowerment of employees by giving timely feedback (Yoder-Wise 2007:294). During performance appraisal, nurse managers should identify limitations in the employee's current performance that will assist the nurse manager and the employee to plan on how limitations can be addressed. Managers can use the following methods to deal with the identified limitations in a supportive manner: formal classroom training; on-the-job training; coaching; mentorship programmes; assignment to project teams for learning; and self-managed learning (Bagraim et al 2011:130).

2.3.1.4.5.5 Fair labour practice

Nurse managers and supervisors should bear in mind the *Labour Relations Act*, 1995 (Act 66 of 1995), as amended, when conducting performance appraisals. The implementation of the *Labour Relations Act* assists managers in enhancing employees' competence in their jobs by improving their knowledge, skills, and abilities by ensuring that there are training programmes available to allow employees to grow personally and

professionally (Grobler et al 2011:340). The act stipulates that if an employee fails to perform to standard, he/she should be offered assistance to improve performance. The nurse manager and the supervisor could assist an employee by offering training, or by reassignment to a different position to help the employee to remain employed (Bagraim et al 2011:127). This provides the employee with an opportunity to improve while receiving support as part of the structural empowerment component. It must be emphasised that all interactions, opportunities and outcomes of training and developmental activities and processes should be well documented, as poor performance may eventually lead to dismissal if improvement cannot be achieved.

Application to Kanter's Theory

Resources is the capacity of an employee to access the material, money, supplies, time and equipment that are needed to accomplish organisational goals (Ning et al 2009:2643). Adequate staffing and resources lead to greater feelings of accomplishment by the employees, which would lead to better outcomes (Manojlovich & Laschinger 2007:257). Employees who cannot access the required resources experience powerlessness and become less committed to their jobs (Faulkner 2008:214). Kanter's theory suggests that employees should be provided with adequate and sufficient resources in order to experience empowerment (Gilbert et al 2010:340). This means that managers should provide employees with adequate resources such as human resources, a fair salary, physical resources, equipment and supplies and technological resources to enable them to meet the organisation's goals (Smit et al 2011:4). This is required in view of the *structural empowerment* component of empowerment according to Kanter's Theory.

2.3.1.5 Formal and informal power

This section focuses on the last two dimensions of *structural empowerment*, the component of Kanter's Theory, namely formal and informal power. The definition of power, types of power and the difference between formal and informal power will be discussed.

Power, encompassing the fifth and sixth dimensions of *structural empowerment*, refers to the ability to influence the behaviour of others in an organisation (Smit et al

2011:223). Power is useful to compel obedience and to control or, to dominate (Huber 2010:260). Kelly (2008:262) classifies the sources of power as connection, legitimate coercion; reward, reference and information power. Whereas Smit et al (2011:223) identify the following types of power, which are found in an organisation:

Legitimate power is the authority which the organisation grants to a particular position. In a hospital, the nursing service manager has the legitimate power to delegate duties to supervisors of departments. According to Kinicki and Fugate (2012:344), legitimate power can be expressed in either a positive or negative manner. Positive legitimate power focuses constructively on job performance, and negative legitimate power tends to be threatening and demeaning to those being influenced. For legitimate power to be effective the employees also must believe that the manager has the right to tell them what to do (Quick & Nelson 2013:349), in this way it provides structure.

Reward power is the power to give or withhold rewards; these rewards could be financial or non-financial rewards. For example, in a nursing college, the head of a department has the power to allocate rewards to employees who have performed well after a performance appraisal. The head can nominate the employee for an incentive, as a form of recognition for work well done and the recognition of the professional developmental needs of employees. Managers have reward power if they can obtain compliance by promising or granting rewards (Kinicki & Fugate 2012:344).

Coercive power is the power to enforce compliance through sanctions or fear, either psychological or physical. The manager can exercise coercive power by disciplining or demoting his/her subordinate. The availability of coercive power may differ from one organisation and manager to another. The presence of union and organisational policies on employee treatment can weaken coercive power (Schermerhorn et al 2012:269).

Referent power refers to personal power. People follow a person with referent power because they like, respect, or identify with him or her. Referent power can be obtained through association, where a subordinate associates himself/herself with the supervisor who is hardworking. For example role models also have referent power over those who identify closely with them (Kinicki & Fugate 2012:345).

Expert power is based on knowledge. A person who possesses expert power has special power over those who have less knowledge and skills in general or in a specific discipline. In clinical practice, a nurse who has a qualification in advanced midwifery has expert power, his/her colleagues will always consult him/her when they experience problems related to the midwifery regimen. Kinicki and Fugate (2012:345) state that expert power also refers to valued knowledge or information that gives an individual expert power**,** for example the power of supervisors is enhanced because they know about work assignments and schedules before their employees do.

Having looked at some sources of power, the discussion will now focus on formal and informal power within the context of empowerment.

- **Formal power**

According to Lucas et al (2008:965), formal power relates to the individual's visibility, discretion, recognition and relevance to the accomplishment of organisational goals. Formal power originates from positional/legitimate power, which is based on the individual's formal position in the organisational hierarchy. Formal power in the nursing unit permits employees to make decisions within the scope of their responsibilities. It implies legitimate authority to control subordinates, or employees' behaviour and to modify organisational structure and processes which includes appropriate in-service education programmes (Bagraim et al 2011:263). In an organisation formal power can be utilised by managers to facilitate achievement of strategic goals (Davoren & Media 2015:2). Therefore employees need to be aware of the goals and objectives of the hospital. Managers have formal power due to the positions they occupy. For example, formal power in a hospital is exercised by supervisors when they support the promotion of a nurse (reward power), whose performance they regard as meeting the required or expected performance standard. Formal power could also encompass coercive power when an employee needs to be disciplined.

All organisations have an organisational chart, which indicates the lines of authority communication channels and allocated divisions, which represents the formal power structure of the organisation (Davoren & Media 2015:1). In small organisations where there may be no formal organogram, it is possible to distinguish levels of formal power

based on the roles, titles, functions and interdepartmental relationships of staff members (Davoren & Media 2015:1).

- **Informal power**

Informal power refers to the patterns of relationships and communication that evolve as employees interact and communicate with one another (Smit et al 2011:224). Informal power develops through alliances (referent power) with sponsors, peers and subordinates within the organisation (Lucas et al 2008:965).

Subordinates should be encouraged to exercise informal power through professional networking to promote sharing of ideas with other nurses.

Informal power means the ability to lead, direct or achieve without an official leadership title (Davoren & Media 2015:2). It also means the ability to effectively network in building successful alliances and coalitions and enables nurses to be skilled at negotiations and conflict resolutions (Quick & Nelson 2013:361). Bryan, Matson and Weiss (2007:2) state that informal power also comes from peer groups, communities of practice, or functional councils.

Manojlovich (2007:3) states that empowered nurses are highly motivated and are able to motivate and empower others by sharing their sources of power. DeVivo, Griffin, Donahue, Fitzpatrick, Commack, Cleverland and Danbury (2010:2) are of the opinion that managers who are able to develop organisational structures that facilitate the empowerment of nurses to deliver optimal care create a greater sense of fit between the nurses' expectations and organisational goals. Employees who access or experience the dimensions of empowerment structures (such as receiving opportunities, information, support, adequate resources and the benefits of power) are more likely to experience motivation and they are more likely to be committed to the organisation. Employees who cannot access these structures experience lower aspirations and are less committed. Structurally empowering work environments are the outcome of leadership practices that foster employees' feelings of respect, employee recognition and trust (Faulkner & Laschinger 2008:215).

Application to Kanter's Theory

Formal and informal power

Formal and informal power structures enhance the empowerment of employees. Formal power is concerned with an employee's position in the organisation whilst informal power comes from the employee's network (Knol & Van Linge 2009:360). Managers should create opportunities for employees to access positional power through the use of discretion, visibility and authority in their nursing units to make independent decisions related to their jobs and by networking with other employees to share ways of solving patient care related problems (Meyer et al 2009:164). The creation of opportunities for employees to use their discretion, and to participate in jobs that are visible in the organisation, is in line with Kanter's Theory which indicates that managers should create empowerment structures that allow employees to access formal and informal power (Gilbert et al 2010:340).

This concludes the discussion of the first component of Kanter's Theory.

2.3.2 Psychological empowerment

Psychological empowerment is the second component of Kanter's Theory of Structural Empowerment. *Psychological empowerment* is divided into four dimensions, namely meaning, confidence, autonomy and impact. The following section focuses on the definition of psychological empowerment, followed by the discussion of each dimension. It is a continuous variable by which individuals perceive themselves as more or less empowered rather than empowered or not empowered (Ergeneli et al 2007:42). A sense of meaning, self-determination, competence and impact constitutes empowerment (Corbally et al 2007:171).

According to Muller et al (2011:70), there are two levels of motivators. The first level includes achievement, recognition, responsibility, and opportunity for growth. The second level is concerned with feelings, job security, and fairness in the workplace, pride, and adequate salary. Generally, in the work situation, managers should ensure that motivators are available for recognising the good performance of employees.

Motivators could include additional pay for outstanding performance, as well as merit raises (Finkelman 2012:341).

2.3.2.1 Meaning

According to Laschinger et al (2009:229), meaning refers to congruence between an employee's beliefs, values, behaviours and job requirements. Onyishi, Ugwu and Ogbonne (2012:303), state that meaning is the value of the task, goal or purpose judged in relation to the individual's own ideas or standards; it involves a fit between the requirements of a work role and a person's beliefs and behaviours. Quick and Nelson (2013:365) concur that meaning is a fit between the work role and the employee's values and beliefs; it is further explained as the engine of empowerment that energises employees about their jobs.

Quick and Nelson (2013:365) further say that employees find meaningfulness in their jobs, their beliefs, values, behaviours and job requirements by empowering themselves through the development of a sense of self-efficacy in order to be able to execute their allocated duties. Cekmecelioglu and Ozbag (2014:3) are of the opinion that an employee who perceives the job requirements as meaningful and personally valuable, will persist in carrying out the assigned task and spend more effort on understanding a problem from various perspectives, searching for a solution using a wide variety of alternatives by connecting diverse sources of information that could be linked to the generation of new ideas and creativity. Kinicki and Fugate (2012:186) however see the process from a different angle where they feel employees need to first be empowered in order to experience meaningfulness about job requirements. The empowerment of employees about job requirements would enable them to experience meaningfulness and to identify the conditions that might foster powerlessness in the workplace. Kinicki and Fugate (2012:185) postulate that goals direct employees' attention and effort toward goal-relevant activities and away from goal-irrelevant activities. Kinicki and Fugate (2012:186) further state that goal setting increases individual, group, and organisational performance. It is therefore important for supervisors to allow their subordinates to set their unit goals, and to appreciate and support the goals that are established by their subordinates to increase the performance of individual employees**.** Managers should promote participative goal setting together with their subordinates, setting challenging and attainable unit goals to motivate employees in order for them to

experience meaningfulness in their jobs. These authors further state that a participative approach stimulates information exchange, which leads to the development of effective task strategies and to higher self-efficacy.

Schermerhorn et al (2012:276) report that empowered employees need to believe that their jobs are meaningful to them and consistent with their values, that they are able to use their competencies, are allowed to use their discretion, make an impact, and they need to believe that they have some choice in how their jobs are performed. Knol and Van Linge (2009:360) say that meaning refers to the level at which people care about their work and feel that it is important. According to Mullins and Christy (2013:279), meaninglessness in employees can be seen as the inability to see the purpose of work done or to identify with the total production process or finished product.

In nursing practice, caring means that the nurse possesses the necessary attitude up-to-date scientific knowledge, skills and experience to provide the nursing care that a patient needs (Mellish et al 2010:4). From the discussion above, it is evident that nurses will experience meaningfulness if the job they do corresponds, or is in line, with their personal beliefs, values and standards. If this is so, then empowerment is generated as the employee would wish to do better and strive to develop or improve his or her competencies so that the task and goal achievement can be executed in a more effective way**.** This could lead to confidence in the work environment. Self-efficacy could make way for greater autonomy in service delivery and thus ensure a greater impact on goal achievement. This supports the *psychological empowerment* component of Kanter's Theory.

Application to Kanter's Theory

Employees find meaningfulness in their jobs, their beliefs, values, behaviours and job requirements by empowering themselves through the development of self-efficacy in order to execute their duties (Quick & Nelson 2013:365). Managers should empower employees in order for them to experience meaningfulness regarding job requirements (Kiniki & Fugate 2012:186), by enhancing the empowerment of employees in view of their tasks, a feeling that they are making a difference in their nursing units, is created (Stander & Rothmann 2010:4), this is in line with Kanter's theory which states that for

employees to experience meaningfulness there should be a fit between job requirements, beliefs and the value of the work role (Quick & Nelson (2013:365).

2.3.2.2 Confidence

According to Kanter's theory, confidence is the dimension that follows after meaning within the component of *psychological empowerment*. The following section will first focus on the dimension of confidence, and thereafter competence as a replacement for 'confidence'. According to *Longman Dictionary of Contemporary English for Advanced Learners* (2009:350), confidence refers to the belief a person has, and the ability to do things well or deal with situations successfully.

Faulkner and Laschinger (2008:216) indicate that Kanter's theory was expanded to incorporate psychological empowerment. According to Haggstrom, Engstrom, and Babro (2009:867), the component of psychological empowerment has four dimensions namely; autonomy, competence, meaning and impact; employees who experience empowerment within these four dimensions are perceived to be satisfied in the psychological empowerment domain.

The reason for discussing both the dimensions of confidence and competence is to show the association that exists between the two dimensions; and to show that most of the studies consulted by the researcher on psychological empowerment focussed on the dimension of competence rather than the dimension of confidence as indicated in Table 2.1. According to Lucas et al (2008:965), Kanter's Theory is divided into three components. The components are s*tructural empowerment*, p*sychological empowerment* and *positive work behaviours and attitudes*. Kanter's Theory was discussed in depth earlier in this chapter under section 2.3. In applying Kanter's Theory, Corbally et al 2007:171; Ebrahim, Dahshan and Hochwalder 2007:205; Faulkner and Laschinger 2007:216; Knol and Van Linge 2009:360; Rawat 2011:143; Wagner et al 2010:449 and Williamson 2007:133 all refer to competence rather than confidence. Thus the dimension of confidence was replaced with competence based on the application of Kanter's Theory in the eight studies done by these noted authors.

Manojlovich (2007:7) states that competence refers to confidence in one's abilities to perform the job. Schermerhorn et al (2012:88) is of the opinion that self-efficacy is

closely associated with the terms confidence, competence and ability. Newstrom (2015:522) states that self-efficacy refers to the internal belief that one has the necessary capabilities and competencies to perform a task, fulfil role expectations, or meet a challenging situation successfully.

Greenberg (2013:253) suggests ways in which employees can project confidence with their words. They should:

- Always know exactly what to say: this means that if the employee is committed to achieving a goal he/she will be better able to express the idea to other employees and sell the set goal.
- Downplay uncertainty: this refers to being positive to the idea even though the employee is not sure whether his idea will succeed or not.
- Ask very few questions: the employee should ask very few questions because if too many questions are asked it might seem that the employee lacks the knowledge pertaining to his or her idea.
- Not display disappointment when their idea is opposed: the person should convey that opposition from others is appreciated and give himself or herself time to explain his or her views or idea.
- Make bold statements: the employee should display boldness but guard against attacking other members.

The ways of projecting confidence show that it is important for employees to know what they want and what they are expected to accomplish, for example to know what the delegated task is, and to know how to accomplish the delegated task according to set standards. Knowing what they want could relate to being assertive in speaking out for their own rights in terms of being provided with a fair work environment.

Application to Kanter's Theory

Manojlovich (2007:7) states that competence refers to confidence in one's abilities to perform the job. Greenberg (2013:253) views confidence as including the ability to perform the job, commitment in achieving organisational goals, and being able to explain one's view to other employees. The literature review on confidence is in line with Kanter's Theory which indicates that an individual should be able to perform the

delegated task, and also to be able to put forward his own views regarding the task. He should also take into consideration other employees' ideas which will assist in achieving the organisation goals Greenberg (2013:253).

Having explained 'confidence' as the second dimension pertaining to psychological empowerment and its strong association with competence, the next section focuses on competence.

- **Competence**

According to the *Longman Dictionary of Contemporary English for Advanced Learners* (2009:338), competence refers to doing something well. According to Ergeneli et al (2007:43), competence is the belief that individuals are able to perform their task activities skilfully. Rawat (2011:143) states that competence refers to self-efficacy specific to work and is rooted in an individual's belief in his or her knowledge and capability to perform task activities with skill and success. Motacki and Burke (2011:193), report that a competent nurse is a person who is qualified and able to perform the work according to professional standards.

Kelly and Marthaler (2011:9), state that competence refers to the on-going ability of a nurse to integrate and apply the knowledge, skills, judgement, and personal attitudes required to practise safely and ethically in a designated role and setting. According to Wilton (2011:453), competence is the ability to perform a specific task or fulfil a function to a desired standard. Competence reflects an individual's belief and confidence that they have the necessary skills and abilities to perform their work well (Stander & Rothmann 2010:3). Capabilities are related to individuals' job performance and the confidence they express in performing at their best ability (Faulkner 2008:216). Marriner-Tomey (2009:55) states that it is important to consider the employee's capabilities (within the scope of practice) and interests when delegating responsibilities. When employees are given the power to make decisions, they should also be given authority to direct the performance of delegated duties. This can be achieved by delegating the necessary authority and power to make decisions.

Nurse managers should ensure that nurses have the power to make decisions and that there are training programmes that are drawn up and implemented to promote

continuous professional and personal development. Kelly (2008:345), further states that competence is the ability to apply knowledge and interpersonal decision-making, and the psychomotor skills expected of his/her practice role. Sullivan (2013:250) states that managers have the responsibility of strengthening the performance and competence of their subordinates by jointly developing action plans to help the employees to improve. Action plans contain the mutually agreed-on activities for improving performance; these developmental activities include formal training, academic course work or on-the-job training.

Competence can be enhanced by participating in continuing education programmes and certification in one's specialty. Keeping up to date – by reading nursing journals and related materials – can add to one's sense of personal achievement as well as pursuing high goal expectations (Whitehead et al 2007:71). It is also important for nurse managers to create a work climate that will motivate healthcare professionals to improve their work performance because the work performance of employees is crucial to organisational outcomes (Jooste 2011:289). Managers should encourage employees to be assertive in expressing their feelings and ideas regarding their performance in a fair work environment (Finkelman & Kenner 2013:99).

Application to Kanter's Theory

Kelly and Marthaler (2011:9) state that competence refers to the on-going ability of a nurse to integrate and apply the knowledge, skills, judgement, and personal attitudes required to practise safely and ethically in a designated role and setting. Competence is visible in the knowledge, skills and judgement illustrated when performing a required task. This is in line with Kanter's Theory which presumes an employee has the ability and belief to carry out the task (Ebrahim et al 2013:3448).

2.3.2.3 Autonomy

Autonomy is the third dimension of *psychological empowerment*. Autonomy means the freedom that a place, an organisation or a person has to govern or control itself (*Longman Dictionary of Contemporary English for Advance Learners* 2009:98). Autonomy refers to the ability to act according to one's own knowledge and judgement, providing nursing care within the full scope of practice defined by existing professional,

regulatory, and organisational rules (Weston 2010:2). Autonomy refers to the personal control individuals perceive to have in their work environments (Faulkner & Laschinger 2008:216). Autonomy is the degree to which a job provides substantial freedom and discretion to the individual in scheduling the work and in determining the procedures to be used in carrying it out (Robbins et al 2010:174). Autonomy encourages job independence, which means that nursing unit managers should allow employees to determine their own work outcomes in their nursing units, make decisions or determine the means to accomplish objectives (Luthans 2011:181).

Autonomy is also defined as the employee's right to self-determination and freedom of decision-making (Huber 2010:156). In clinical practice managers should advance autonomy by allowing employees to complete delegated tasks independently, without being questioned by a supervisor (Jooste 2011:235). Managers should constantly encourage employees to perform at their best or to function successfully by demonstrating that they have the ability to solve problems in rapidly changing and uncertain situations (Jooste 2011:275). Autonomy is the characteristic that gives employees discretion and control over job-related decisions and autonomy appears to be fundamental in building a sense of responsibility in employees (Newstrom 2011:273) which engenders a sense of empowerment.

Roussel (2013:232) is of the opinion that professional employees seek autonomy in practicing their profession and making decisions about their work rather than having their decisions made for them by hospital administrators and physicians. They want to be treated as equal partners and colleagues in the healthcare delivery system. Autonomy is also seen as the absence of formal control systems such as target setting mechanisms, measurement and reporting channels, and centralised decision-making in the organisation. The existence of clear goals for managers without the addition of these formal systems means that the controls remain in place, but they are far less intrusive and allow managers personal freedom to decide how the goals will be achieved (Mullins & Christy 2013:651). An organisation that provides nurses with autonomy has better patient outcomes; retains nurses at a higher rate; is more cost-effective; and provides evidence of greater patient satisfaction (Yoder-Wise 2007:374). Managers can enhance autonomy by setting clear expectations for autonomous decision-making and by providing support to increase the knowledge and expertise of nurses (Weston 2010:2).

Application to Kanter's Theory

Autonomy gives employees the opportunity to use their discretion and independence regarding their work (Robbins et al 2010:174). Autonomy in clinical practice implies that managers should allow employees to make independent decisions regarding their work and to be involved in participative decision-making. The giving of autonomy to employees is in line with Kanter's Theory which states that employees should be given control over decision-making which would lead to a sense of being empowered (Faulkner & Laschinger (2008:216).

- **Impact**

According to the *Longman Dictionary of Contemporary English for Advanced Learners* (2009:879), impact refers to having a noticeable effect on someone or something. Ergeneli et al (2007:43), say impact is the degree to which an individual can influence strategic, administrative or operating outcomes of work. Whereas Pope (2014:20), views impact as a measure of the stakeholder's organisational effect on issues and outcomes. The cited definitions of impact indicate that organisations should create environments that encourage employees to contribute positively to the accomplishment of the organisation's purpose or task (Stander & Rothmann 2010:3).

Impact also means a sense of progression towards a goal and individuals' belief that their actions are making a difference in their organisations, which contributes to employee engagement (Stander & Rothmann 2010:4). Employee engagement creates a feeling of belonging and the opportunity to develop and use personal skills and abilities to make a contribution that is acceptable and appreciated by the organisation (Mullins & Christy 2013:746). Impact also refers to the level at which people (can) leave their mark on the workplace, and whether the organisation takes their ideas seriously (Knol & Van Linge 2009:36). In clinical practice supervisors can create work environments that allow employees to make a mark in their organisations by allowing them to contribute to decision-making by giving ideas, inputs in administrative policies, strategies and objectives of the organisation and to take part in participative decision-making relating to their jobs (Dobre 2013:54).

Managers can facilitate accomplishment in achievement of the organisation's goals by creating opportunities for subordinates to interact with other professionals through networking. These opportunities include attendance of seminars, workshops or conferences where valuable new knowledge is learned by both unit managers and employees. Here they get the opportunity to verbalise their own thoughts on professional matters and test their own opinions against those of others (Meyer et al 2009:164), thus gaining confidence in interaction, networking, sharing of ideas to the extent that individuals realise that they could influence processes, conduct and behaviour which impacts positively on their organisational goals *(psychological empowerment)* and self-development and growth. Furthermore, feedback from supervisors promotes the personal and professional development of employees.

In the history of the nursing profession, there have been leaders who have made an impact on the growth of the profession and who have positively influenced the clinical nursing practice. Florence Nightingale for example, believed that nurses had the responsibility to influence the clinical environment. Nurses, she argued, could impact the clinical environment by ensuring that there were clean air, pure water, efficient drainage, cleanliness and light (Armstrong, Bhengu, Kotze, Nkonzo-Mtembu, Ricks, Stellenberg, Van Rooyen, & Vasuthevan 2013:11). These principles still hold today - evidence of Florence Nightingale's impact as a powerful person in creating a conducive health environment. Nurses in South Africa today control the nursing profession through the South African Nursing Council. Through their elected representatives voicing their opinions they are also making an impact on political processes, and influencing new legislation (Armstrong et al 2013:15). Thus they influence the administrative processes and assist in policy-making.

Application to Kanter's Theory

Impact means a sense of progression towards a goal and individuals' belief that their actions are making a difference in their organisations, which contribute to employee engagement (Stander & Rothmann 2010:4). Employees' innovative behaviour can lead to valuable contributions that could lead to the achievement of organisational goals (Knol & Van Linge 2009:369). Managers should create engaging work environments and autonomy-supportive work climates that appreciate and take into consideration their employees' views (Stander & Rothmann 2010:9). This will enhance the empowerment

of employees and make it possible for them to participate in shaping the organisational system in which they work (Rawat 2011:144). The creation of workplace environments that encourage employees to contribute to the accomplishment of the organisation's purpose or task will empower employees (Stander & Rothmann 2010:3). This view is in line with Kanter's Theory which states that impact is a sense of being able to influence important outcomes within the organisation which contributes to the feeling of being empowered by employees (Laschinger et al 2009:229).

2.3.3 Positive work behaviours and attitudes

The third and last component of Kanter's *Theory of Structural Empowerment* relates to *positive work behaviours and attitudes*, encompassing four dimensions, namely job satisfaction, commitment, low stress and low burnout. It is therefore important to first define behaviours and attitudes before discussing the four dimensions categorised under *positive work behaviours and attitudes.*

- **Definition of work behaviour**

According to the *Longman Dictionary of Contemporary English for Advanced Learners* (2009: 2020), work refers to doing a job that a person is paid for. Behaviour refers to the way someone behaves (*Longman Dictionary of Contemporary English for Advanced Learners* (2009:137). Employees are normally engaged in a specific type of behaviour which is workplace related and interact with the aim of fulfilling the organisation's goals. According to Griffin and Moorhead (2014:78), workplace behaviour refers to a pattern of action by the members of an organisation that directly or indirectly influences organisational effectiveness.

Griffin and Moorhead (2014:78) state that employees display certain behaviours in the workplace that can affect the organisation. An employee who stays away from work without a valid reason will directly affect the organisation by creating a shortage of staff and subsequently the quality of nursing care will drop; and patients might be dissatisfied with the service provided to them. The outcome of workplace behaviour can either have a positive or negative impact on the organisation. The impact of work behaviour on the organisation can be seen in performance and productivity, absenteeism and turnover, and organisational citizenship (Griffin & Moorhead 2014:78).

Dysfunctional behaviour

According to the *Longman Dictionary of Contemporary English for Advanced Learners* (2009:529), dysfunctional refers to not following the normal patterns of social behaviour, especially with the result that someone cannot behave in a normal way or have a satisfactory life. Griffin and Moorhead (2014:79) state that dysfunctional behaviour refers to those behaviours that prevent employees from accomplishing the organisation's goals. Examples of dysfunctional behaviour that does not contribute to the organisation's effectiveness are absenteeism and turnover. Absenteeism happens when an employee does not report for duty. Dysfunctional behaviour such as unlawful absenteeism occurs when an employee pretends to be sick and uses it as an excuse to stay away from work (Griffin & Moorhead 2014:79).

Turnover happens when an employee decides to leave the organisation. Turnover and absenteeism have a negative impact on the organisation (Griffin & Moorhead 2014:81). If an employee is absent from work the employer has to find a replacement in order to ensure that the goals of the organisation are achieved. It therefore means that the organisation will be affected negatively because another employee will have to be requested to do overtime; and the replacement will also have to be paid for performing delegated duties and patients will not necessarily receive optimal care (Meyer et al 2009:244). Other dysfunctional behaviours of employees include sabotage, and stealing from the company which includes theft of medications and hospital linen (Griffin Moorhead & 2014:81). Such behaviour results in direct financial costs to the organisation (Griffin & Moorhead 2014:80). Another example of dysfunctional behaviour is when an employee fails to maintain confidentiality about the diagnosis of a patient. This can have a negative effect on the image of the patient and of the organisation.

- **Organisational citizenship**

According to the *Longman Dictionary of Contemporary English for Advanced Learners* (2009:289), citizenship refers to the legal right of belonging to a particular country. Organisational citizenship means the behaviour of individuals who make a positive contribution to the organisation (Griffin & Moorhead (2014:80). The performance of an employee who contributes positively to the organisational goals produces quality and

quantity at the same time. When an employee puts extra effort into achieving the organisational goals it is seen as positive organisational citizenship behaviour.

An employee who contributes positively to the organisation talks in a constructive way about the organisation and gives inputs for improvement of his or her nursing unit. Negative behaviour may be seen when an employee is not willing to work extra hours during staff shortages when requested to do so by the supervisor.

- **Attitudes**

According to the *Longman Dictionary of Contemporary English for Advanced Learners* (2009:357), attitude refers to the opinion and feelings that one has about something, especially when it is shown in one's behaviour. Ivancevich et al (2014:70) state that an attitude is a mental state of readiness learned and organised through experience that exerts a specific influence in the way a person responds to people, objects, and institutions with which he/she is related. Greenberg (2013:139) confirms that attitudes are relatively stable clusters of feelings, beliefs, and behavioural predispositions (intensions) toward some specific object, person, or institution. These definitions suggest that an employee who is dedicated to the goals and objectives of the institution and to patient care may volunteer to assist with patient care when one member of the staff is booked off sick or if there is a shortage of staff in the nursing unit.

Robbins et al (2010:59) and Kreitner and Kinicki (2013:158) suggest that attitude has three components, namely an affective, cognitive and behavioural component.

Affective component: According to the *Longman Dictionary of Contemporary English for Advanced Learners* (2009:28), affective means having an effect on the emotions. The affective component refers to the emotional or feeling segment of an attitude (Robbins et al 2010:59). An individual experiencing affective attitudes has little or no conscious control over it (Griffin & Moorhead 2014:72).

Cognitive component: According to the *Longman Dictionary of Contemporary English for Advanced Learners* (2009:314), cognitive is the process of knowing, understanding and learning something. The cognitive component refers to the knowledge that the person has about a particular thing, person or situation (Greenberg 2013:140). The

cognitive component can be applied in clinical practice; a nurse educator can teach a learner nurse to feed a patient who is unable to feed him or herself due to illness. The nurse educator can use role modelling when teaching the nurse learner. The nurse educator will demonstrate the procedure to the learner; whilst the learner observes the teacher. Then the learner will also be given an opportunity to demonstrate the skill.

Behavioural component: Kreitner and Kinicki (2013:158) state that the behavioural component of attitude refers to how an individual would react towards someone or something. The behavioural component means that an individual has some intention of behaving in a certain way towards another person or to something. A nurse who did not succeed during an interview may develop negative feelings towards the interview panel thinking that the panel planned to fail him or her. Stress in the workplace can lead to a change of attitudes in employees who may consequently experience less job satisfaction, an inability to perform at high levels or might just do enough work to get by for the day (Griffin & Morehead 2014:193). A nurse who experiences low morale might become less committed in performing allocated duties due to lack of job satisfaction, arising from lack of resources to perform duties. It is therefore important for managers to understand the attitude of employees towards their job. Managers can promote good attitudes by making use of employee engagement in having a say in decision-making regarding job-related activities (Griffin & Morehead 2014:74). Employee engagement involves participatory decision-making because work attitudes can influence the way an employee will act when making decisions pertaining to patient care and towards the organisation. Lack of employee engagement in decision-making might cause the employee to search for another job in another organisation (Kreitner & Kinicki 2013:162).

The following section will now focus on the specific dimensions of *positive work behaviours and attitudes*.

2.3.3.1 Job satisfaction

Job satisfaction is the first dimension pertaining to *positive work behaviours and attitudes*.

- **Definition of job satisfaction**

According to the *Longman Dictionary of Contemporary English for Advanced Learners* (2009:943), job satisfaction means the enjoyment you get from your job. Jacobs and Roodt (2008:66) define job satisfaction as referring to a worker's general attitude towards his or her job. Luthans (2011:141) state that job satisfaction is the result of employees' perception of how well their job provides the things that are seen as important. According to Mullins and Christy (2013:783), job satisfaction is an attitude or internal state that is associated with a personal feeling of achievement which could be either quantitative or qualitative in nature.

Kekana, Du Rand and Van Wyk (2007:25) state that job satisfaction relates to the working conditions, emotional climate and social working climate. For example, a social working climate is concerned with the interactions that occur between employees. Nurses prefer to work in an environment with good team spirit; and where they are able to communicate freely with their nursing and medical colleagues. The findings from the research of Kekana et al (2007:25) further emphasise the importance of creating a caring environment for nurses.

- **Definition of job dissatisfaction**

According to Jianguo and Frimpong (2010:1) job dissatisfaction refers to the psychological condition of an employee caused by unravelled conditions at work.. Grohar-Murray and Langan (2011:198) differentiate between job satisfiers and job dissatisfiers. These authors state that dissatisfiers are factors that are extrinsic to the job − they include salary, the condition of the surroundings, and policies − whereas satisfiers are factors that relate to the work itself. They include responsibility and achievement. Whereas Kinicki and Fugate (2012:151) state that a person will not suffer from job dissatisfaction if he or she does not have grievances.

2.3.3.1.1 Reasons for job satisfaction

Kinicki and Fugate (2012:161) identify the following as reasons for experiencing job satisfaction.

Need fulfilment. This means that satisfaction is determined by the extent to which the characteristics of a job allow an individual to fulfil his or her needs. Job satisfaction stems from expectations that are met (Kinicki & Fugate 2012:161)**.** Met expectations indicate what an individual expects to receive from a job, such as fair pay and promotional opportunities, and what he or she actually receives. When the expectations of an employee are greater than what he or she receives from the employer; the employee will feel dissatisfied and if the employee receives outcomes above and beyond expectations, the employee will be satisfied (Kinicki & Fugate 2012:162).

Value attainment, which is that satisfaction that results from the perception that a job allows for the fulfilment of an individual's important work values; value fulfilment is positively related to job satisfaction. Managers can promote employee satisfaction by structuring the work environment and its associated rewards and recognition to reinforce employees' values, such as the protection of the patient's rights, honesty and compassion.

Equity. This relates to how fairly an individual is treated at work. Managers should monitor employees' fairness perceptions and interact with employees in such a way that they feel equitably treated. This could relate to a workplace that is free from harassment.

Dispositional/genetic components. These components or characteristics are based on the belief that job satisfaction is primarily a function of both personal traits and genetic factors. This implies that stable individual differences are as important in explaining job satisfaction as characteristics of the work environment, as an individual's job satisfaction can be is associated with his/her dispositional or genetic characteristics. Newstrom (2015:233) argues that job satisfaction is a set of favourable or unfavourable feelings and emotions with which employees view their work. Mullins and Christy (2013:783) describe job satisfaction as an attitude or internal state that is associated with a personal feeling of achievement. Abraiz, Tabassum, Raja and Jawad (2012:395) state that job satisfaction is an attitudinal behaviour which reflects an individual's assessment of his or her job.

2.3.3.1.2 Factors that affect job satisfaction

Horwitz and Pundit (2008:28), postulate that job satisfaction is affected by a number of factors. These factors can be categorised as follows:

Personal factors. Arabaci (2010:2083) suggests that job satisfaction can be affected by individual factors such as gender, age, marital status, status, seniority, and talent. Personal factors also include education, intelligence, abilities and personality.

Organisational factors. These include an individual's perception of management, salary, autonomy, work demands and training opportunities; for example an employee may expect that a supervisor should be approachable and friendly, easy to talk to about concerns, cool and calm most of the time and willing to praise employees for good work (Grohar-Murray & Langan 2011:155). Organisational factors also include the work itself, opportunities for promotion, the supervision process, salary, social rights, relationships within the organisation, workmates and relationships with administrators. High work satisfaction might lead to intrinsic motivation such as achieving job outcomes which will lead to feelings of accomplishment of delegated responsibility and recognition thereof by the supervisor. Satisfied nurses become more committed to their jobs and are productive, whereas dissatisfied nurses are prone to be absent more often have grievances and often change jobs (Guleryuz, Guney, Aydin & Asyn 2008:1627).

Social factors. These are relationships and cohesion with nursing peers, doctors and allied staff and patients. Mullins and Christy (2013:783) state that social factors include working groups and norms, opportunities for interaction and informal organisation.

Cultural factors are concerned with underlying beliefs and attitudes that contribute to behaviour and are key components which impact on job satisfaction among nurses.

2.3.3.1.3 How job satisfaction can be promoted

According to Horwitz and Pundit (2008:28), the following factors are necessary to ensure job satisfaction among nurses: adequate pay, professional status, social integration, minimal non-nursing task requirements, and good organisational policies

and autonomy. Non-nursing tasks include transporting patients for routine procedures, and delivering or picking up meal trays.

Roussel (2013:266) indicates that employees want a work climate that promotes job satisfaction through good working conditions, high salaries, opportunities for professional growth and career development, challenging work, recognition of achievements and involvement in decision-making. Roussel (2013:488) further states that setting specific challenging goals that are accepted by employees can increase motivation because they have targets and objectives to work toward.

Managers can assess the level of job satisfaction of their employees by means of interviews and questionnaires, and through careful observation and interpreting what people say while performing their jobs (Schermerhorn et al 2012:64). Job satisfaction is highest among employees who believe that their supervisors are competent, treat them with respect and have their best interest in mind. It is enhanced when employees believe that they have open lines of communication with their supervisors (Greenberg 2012:158).

Managers should also match employees with jobs that fit their interests and skills; this means that the manager should consider the knowledge and skills and the scope of practice of each employee in order to facilitate job satisfaction (Luthans et al 2011:146). Managers can also lessen job dissatisfaction by increasing employee autonomy, recognition of work well done and by using flexi-scheduling of off duties in their nursing units.

2.3.3.1.4 The result of job satisfaction

Employees who are satisfied with their work are more engaged, productive, creative, and committed to their organisation (Moneke & Umeh 2014:150). When nurses are satisfied with their jobs they tend not to leave the organisation (De Gieter et al 2011:1563). Satisfied employees tend to be friendly and responsive to patients' needs and patients appreciate employees that are friendly (Robbins et al 2010:71). Employees who are satisfied with their jobs do not absent themselves from work unnecessarily, but those who are dissatisfied tend to leave their organisations and seek alternative jobs in other organisations (Schermerhorn et al 2012:66).

The many aspects and variables noted above as contributing factors to an individual experiencing job satisfaction, also provide opportunities for growth, development, specialisation, recognition, autonomy, and commitment which are all empowering agents. These are aspects mostly created by *positive work behaviours and attitudes* of managers and colleagues, but also of the individual nurse as one's inclination towards a positive attitude to most things in life often depends on a person's genetic composition and personality.

Application to Kanter's Theory

Job satisfaction is the result of employees' perception of how well their job provides the things they perceive as important (Luthans 2011:141). Job satisfaction is facilitated when employees receive adequate pay, are granted a professional status, are not required to perform non-nursing tasks are guided by good organisational policies and have autonomy (Horwitz & Pundit 2008:28). The growth variables which enhances job satisfaction, have an empowering effect as employees feel they are better equipped and prepared to do their work, and may even facilitate upward mobility in terms of career progression. The literature review on job satisfaction supports Kanter's Theory which postulates that job satisfaction can be an empowering dimension.

2.3.3.2 Commitment

Commitment refers to the work, belief, and loyalty that a person gives to a system or organisation (*Oxford Popular School Dictionary* 2008:79). Commitment refers to an individual's identification with, and involvement in, the organisation, characterised by a strong belief in, and acceptance of the organisation's goals and values and a willingness to exert considerable effort on behalf of the organisation (Rawat 2011:144).

- **Organisational commitment**

Organisational commitment is a state in which an employee identifies with a particular organisation, and its goals and wishes in order to maintain membership with the employing organisation (Robbins et al 2010:63). Organisational commitment is based on behaviours and/or attitudes that involve the relationship that an employee has with

an organisation (Moneke & Umeh 2014:155). Commitment is the expression of continued dedication to a common purpose and to achieving goals (Mullins & Christy 2013:710). Employees will not be able to commit themselves to the values of the organisation if they experience organisational conflict or disagreement (Tyson 2015:318). Employees may be committed to their employing organisations if they feel confidence in their employers' commitment to them (McKenna & Beech 2014:173). Commitment is further viewed as representing loyalty to the organisation and a desire for involvement in an organisation (Ambad & Bahron 2012:75). A study conducted by De Gieter, Hofmans and Pepermans (2011:1563) on job satisfaction and organisational commitment reveals that nurses who are satisfied with their jobs are less likely to leave and that the stronger the nurses' commitment to their organisations, the less turnover will be experienced. According to Mellish et al (2010:6), commitment means to accept the values and responsibilities that are part of nursing. These values include observing ethical norms and standards, concern (caring) for the person in need of care; and cooperation with other members of the health team. This means that nurses must accept responsibility for the maintenance of their own competences by attending relevant in-service training and workshops organised by the supervisor.

In clinical practice supervisors should facilitate the setting and maintenance of standards for high quality patient care by ensuring that employees display commitment to the standards, by self-evaluation against the set standards and by encouraging nurses to provide the best possible quality patient care using the available resources (Mellish et al 2010:129). Commitment can also be viewed as part of the psychological contract which is an unwritten contract between management and employees, whereby management offers challenging and meaningful tasks and employees reciprocate with loyalty and commitment (McKenna & Beech 2014:11). Without committed and empowered employees, the organisation can never provide good service, or reach its full potential (Blanchard 2007:4). When employees have access to empowering structures such as opportunity, support and formal and informal power, there is a possibility of them becoming motivated and more committed to the organisation. whereas employees who do not have access to such empowering structures and have to deal with a lack of resources feel powerless and become less committed to the organisation's objectives and to their work (Faulkner & Laschinger 2008:216).

According to Robbins et al (2010:63), there are three dimensions to organisational commitment, namely affective commitment, continuance commitment and normative commitment.

- **Affective commitment:**

According to the *Longman Dictionary of Contemporary English for Advanced Learners* (2009:28), affective means having an effect on the emotions. Affective commitment refers to an employee's intention to remain in an organisation because of a strong desire to do so (Newstrom 2015:236). Affective commitment is also viewed as the employee's emotional attachment to the organisation and a belief in its values (Robbins et al 2010:63). The employee's attachment to the organisation is seen through an increase in job involvement, attendance, performance, job satisfaction, low rates of attrition and decreased intention to leave the organisation (Smith, Andrusyszyn & Laschinger 2010:1007). Employees who experience low affective commitment are more likely to miss work and engage in counterproductive behaviours such as theft, sabotage and aggression (Morrow 2011:19).

Managers can enhance affective commitment by communicating to employees that they value their contributions and that they care about their well-being (Quick & Nelson 2013:118).

- **Normative commitment**

According to the *Longman Dictionary of Contemporary English for Advanced Learners* (2009:943), normative refers to the establishment of a set of rules or standards of behaviour. Normative commitment is perceived as an obligation to remain with the organisation; employees believe that they owe it to the organisation. For example an employee who is heading a new project or idea may remain with an employer because the employee feels that if he or she leaves the organisation the project will not be continued or will not succeed (Robbins et al 2010:63).

Affective and normative commitments are related to lower rates of absenteeism, higher quality of work, and increased productivity and performance. Performance can be increased by providing in-service education and training of employees.

- **Continuance commitment**

Continuance commitment refers to an employee's tendency to remain in an organisation because he or she cannot afford to leave, the employee focuses on the economic value of remaining with the organisation rather than to leave. Employees under this type of commitment believe that they will lose a lot of benefits if they leave because the employee feels that the salary paid to him/her is according to the type of work that he or she is performing and if the employee leaves the organisation the family will lose because the family's needs will not be met or he/she might lose the chances of being promoted to a higher position (Robbins et al 2010:63).

- **Professional commitment**

Drey, Gould and Allan (2009:741) describe professional commitment in addition to organisational commitment. Professional commitment can be seen in employees' attitude to their work and their behaviour in relation to commitment. A high level of commitment is associated with the profile of nursing and the extent to which nursing is esteemed by patients and the public. Employees who experience high levels of professional commitment take pride in their occupation and strive to perform better and they are likely to be more satisfied at work (Drey et al 2009:741). Professional commitment can be promoted when an employee identifies with the leader and follows his/her example, working as hard as the role model to complete the delegated task. The commitment of the manager will engender commitment in the employee (Griffin & Moorhead 2014:381).

Application to Kanter's Theory

Employees commit themselves to their organisation with the aim of identifying themselves with the organisation that they work for; and by accepting the organisation's goals and values (Rawat 2011:144). Managers should enhance the commitment of employees by giving them autonomy to make decisions about work methods and allow them to determine their work outcomes (Ambad et al 2012:78). Promotion of organisational commitment will encourage employees to be more productive and will commit themselves to the organisation's goals. The promotion of organisational commitment is in line with Kanter's Theory which indicates that empowerment of

employees is achieved by creating organisational commitment where employees are able to identify with the organisation and work towards the performance of their duties (Chegin & Kheradmand 2013:1048).

2.3.3.3 Low stress

In order to deal with low stress levels as a dimension enhancing empowerment, it is necessary to first explain what stress is and what the causes of stress in the workplace are.

2.3.3.3.1 Definition of stress

According to the *Longman Dictionary of Contemporary English for Advanced Learners* (2009:1745), stress means the continuous feelings of worry about your work or personal life that prevent you from relaxing**.** Moorhead and Griffin (2012:180) define stress as a person's adaptive response to a stimulus that places excessive psychological or physical demands on the person. Finkelman and Kenner (2013:215) describe stress as a complex experience, which is felt internally, that makes a person feel a loss or a threat of loss.

Stress is also seen as a dynamic condition in which a person is faced with an opportunity, a demand, or a source about what the person aspires to have and of which the results might appear to be uncertain (Robbins et al 2010:533).

In the next section the consequences of stress are discussed. They are divided into individual, behavioural, psychological and organisational consequences of stress.

2.3.3.3.2 Consequences of stress

According to the *Longman Dictionary of Contemporary English for Advanced Learners* (2009:357), consequence refers to bad or unpleasant results. Moorhead and Griffin (2012:189) say that the consequences of stress may be divided into individual consequences and organisational consequences. Whereas Robbins et al (2010:537) divide the consequences into physiological, psychological and behavioural symptoms.

- **Individual consequences of stress**

Griffin and Moorhead (2014:191) further state that individual consequences of stress are the outcomes that affect mainly the individual, and the organisation. The organisation might be affected directly or indirectly by the outcome of individual stressors. The organisation will be affected directly if a patient takes legal action against the hospital due to the negligence of a nurse. The organisation will be affected indirectly by the outcome of individual stressors less patients will come for treatment at these hospitals because of fear of negligence.

The physical consequences of stress affect the individual's well-being. Physiological symptoms of stress include alteration in blood pressure, nausea, indigestion, pain in the neck, shoulder muscles and lower neck (Meyer et al 2009:279). This may lead heart disease and stroke, headache, backache and acne (Moorhead & Griffin 2012:190).

The individual suffering from the consequences of stress may experience physical symptoms such as heart disease and stroke, headaches, backache and acne (Moorhead & Griffin 2012:190).

- **Psychological consequences of stress**

According to Griffin and Moorhead (2014:192), psychological consequences of stress refer to a person's mental health and well-being. People who experience too much stress at the workplace might feel depressed, sleep a lot or they might feel that they do not sleep enough and might experience family problems. Robbins and Judge (2013:635) suggest that other symptoms of stress are tension, anxiety, irritability, boredom and procrastination. Psychological consequences of stress may interfere with the interaction and the work relationships of managers and their subordinates; for example if managers or supervisors are moody subordinates will find it difficult to communicate freely with them; this leads to communication breakdown (Luthans 2011:296).

- **Behavioural consequences of stress**

According to Griffin and Moorhead (2014:191), stress might be harmful to the person who is experiencing the stress, and the outcomes of stress might also be harmful to other people, including those who are closest to the person suffering from stress such as a spouse, colleagues and family members. People who are suffering from stress may smoke a lot, especially when they are faced with challenging stressful situations, they may also abuse alcohol and drugs, be prone to accidents, and they might be aggressive, violent and develop eating disorders. For example, if a nurse experiences stress due to marital problems, or if she abuses alcohol, she may administer a wrong dose of medication to a patient. Other behavioural consequences of stress are anxiety, lowered self-esteem, aggression, apathy and depression (Gibson et al 2012:203). Behavioural consequences of stress may be seen through changes in productivity, absence from work, turnover and the individual may present with sleeping disorders (Robbins et al 2010:537). The explanation of the behavioural consequences of stress by Robbins et al (2010:537) indicates that managers should take note of the negative consequences stress might have on the achievement of the organisational goals.

- **Organisational consequences of stress**

Moorhead and Griffin (2012:190) suggest that organisational consequences of stress may be evident in a decline in performance, withdrawal and negative changes in attitude by affected employees.

Performance

According to the *Longman Dictionary of Contemporary English for Advanced Learners* (2009:1291), performance refers to how well or badly a person does a particular job or activity. Ivancevich et al (2011:182) state that performance is a set of employee work-related behaviours designed to accomplish organisational goals. Moorhead and Griffin (2012:190) suggest that organisational consequences of stress lead to a decline in performance of employees resulting in poor quality of work and a drop in productivity. Managers who experience too much stress might make incorrect decisions or cause disruptions in the workplace and interruptions in working relationships (Moorhead & Griffin 2012:190).

Greenberg (2013:122) states that not all employees in the workplace respond to stressful situations in the same way, and further suggests that poor performance of employees is not always related to stress. Some people who experience stress tend to be motivated and perform above set standards when faced with challenging stressful events because they are highly skilled and confident about delegated tasks.

Withdrawal

According to Mullins and Christy (2013:276), withdrawal refers to apathy, giving up or resignation. Subordinates who experience withdrawal may report sick more often, may not want to accept delegated duties and might not have a sense of duty. Stress can lead to withdrawal which can be manifested in an employee through absenteeism, quitting the job, and reporting sick or leaving the organisation for good. Withdrawal in people who are in management positions can be seen through missing of work deadlines, or taking longer lunch breaks as a way of moving away from the stimulus that is causing the stress (Moorhead & Griffin 2012:190). The withdrawal of employees from the workplace has negative consequences for the organisation. The remaining employees in the organisation will experience a shortage of staff, fatigue and work overload. This will lead to high levels of stress especially in employees who find it difficult to deal with stressful events or situations.

2.3.3.3.3 Sources of work stress

Sources of work stress are classified as organisational and life stressors. These stressors can influence the performance of employees in the workplace.

Olusegn, Oluwasayo and Olawyim (2014:147) identifies the following as factors causing stress: individual (internal) stressors which arise from an individual perception of an environmental threat, and external stressors which include lack of opportunity for advancement, excessive responsibilities, ambiguous demands, value conflict, unrealistic workloads, and adverse working conditions such as excessive noise, extreme temperatures, or overcrowding.

Whereas Wilton (2011:418) view is that work-related stressors include the nature of work being undertaken, the individual's capacity, and workplace relationships. According to Yoder-Wise (2007:533), work-related stressors that might also increase frustration and distress due to changes in work design are one-way communication and a shortage of nurses. Research findings show that stress-related factors in the workplace include shortage of knowledgeable nurses; absenteeism; doctors' demands; lack of support from management and colleagues; and stress caused by temporary nurses from external agencies (Moola, Ehlers & Hattingh 2008:82).

- **Organisational stressors**

Griffin and Moorhead (2014:184), divide the causes of stress into organisational stressors and life stressors. Griffin and Moorhead (2014:185) further indicate that there are factors in the workplace that lead to stress, namely task demands, physical demands, role demands and interpersonal demands. Other factors that could lead to stress at an organisational level include structure and climate. The degree of involvement in decision-making could lead to a stressful climate (Olusegun, Oluwasayo & Olawyim 2014:146). Gibson et al (2012:201) postulates that inadequate career development opportunities can lead to stress; career variables may cause stress if an employee believes that promotion progress is inadequate or if an employee is dissatisfied with the match between career aspirations and the current position.

Task demands

According to the *Longman Dictionary of Contemporary English for Advanced Learners* (2009:448), demands are the difficult, annoying, or tiring things that a person needs to do. Robbins et al (2010:534) state that demands are responsibilities, pressures, obligations and uncertainties that individuals face in the workplace. According to the *Longman Dictionary of Contemporary English for Advanced Learners* (2009:1804), task refers to giving someone the responsibility for doing something. Task demands refer to stressors that are associated with a specific job a person performs or which the person is expected to carry out. Task demands include overload. Overload occurs when one has more work than one can handle (Moorhead & Griffin 2012:185). For example work overload and time deadlines place employees under pressure and lead to stress. The pressure that is experienced by employees usually comes from management, and it

may also be due to poor quality of management; for example an autocratic leadership style whereby the supervisor instructs subordinates through downward communication when giving job-related instructions may contribute to stress (Newstrom 2015:412). The leader who uses an autocratic leadership style may contribute to stress by deciding what is to be done, how it should be accomplished and who should do it, thus placing an employee under pressure (Jooste 2011:64).

Too much stress is undesirable as it can cause tension. Too little stress can lead to boredom and apathy and is accompanied by low performance. Both too much stress and too little stress lead to low performance. However, employees who operate at an optimal level of stress exhibit high energy and motivation and performance which is needed for the accomplishment of delegated responsibilities (Moorhead & Griffin 2012:186).

Physical demands

According to Moorhead and Griffin (2012:185), physical demands are stressors that are associated with the job's physical setting, namely adequacy of temperature and lighting, office design and the physical requirements of the job. For example, temperature relates to working in an improperly heated or cooled, or poorly designed office. Electronic devices that are used by employees such as computers, copiers and fax machines produce radiation which can be harmful to the physical health of the employee (Olusegun et al (2014:147).

Role demands

According to Luthans (2011:290), role is defined as a position that has expectations evolving from established norms. Role demands refer to stressors that are associated with the role a person is expected to perform. A role is described as a set of expected behaviours associated with a particular position or organisation. Griffin and Moorhead (2014:186) state that a particular position in an organisation or in a group has a formal, informal and social requirement. The position that a person occupies in an organisation could lead to stress if the requirements of the job are higher than the abilities of that person. Role demands include role ambiguity, and role conflict (Griffin & Moorhead 2014:186).

Role ambiguity

Role ambiguity refers to a role that is unclear (Griffin & Moorhead 2014:186). Role ambiguity can be manifested when an employee is unsure of what work activity is to be carried out. Role ambiguity might arise from unclear job descriptions, or incomplete orders given by a supervisor. Unclear expectations might interfere with the ability of the employee to function effectively as a team member (Luthans 2011:350). Role ambiguity can be a cause of stress if an employee finds it difficult to understand the delegated task (Griffin & Moorhead 2014:187). Changes in work design are sometimes made by nurse managers without giving proper direction, or with little input from nurses. If nurses are not given adequate support on how to carry out delegated tasks it can lead to distress (Yoder-Wise 2007:533).

Role conflict

According to Griffin and Moorhead (2014:187), role conflict occurs when the messages and cues constituting a role are clear but contradictory or mutually exclusive. Luthans (2011:350) state that role conflict arises when a person is delegated to perform conflicting tasks or delegated to perform tasks that are not in line with his or her personal values. If a nurse values life, and is allocated to a nursing unit where termination of pregnancy is carried out, the nurse might experience role conflict with personal values. The nurse might not be productive in that unit. Role conflict may be experienced by an employee if the supervisor forces the employee to get along with people with whom he or she does not get along with in a group (Ivancevich 2011:246). Role overload happens when expectations for the role exceed the employee's capabilities (Griffin & Moorhead 2014:187).

Interpersonal demands

Interpersonal demands are stressors that are associated with group pressures, leadership, and personality conflicts *(*Griffin & Moorhead 2014:187). Group pressure may occur when an employee as the member of the group is expected to conform to the group's norms in order to reach consensus (Luthans 2011:350). Lack of group cohesiveness could lead to stress if team members do not work together as one team (Luthans 2011:283). Interpersonal demands can also lead to stressful situations from

relationships at work with supervisors, colleagues, and with other employees (Olusegun et al 2014:146). In the workplace negative relationships include verbal abuse, and a lack of respect from nurse managers, nursing colleagues, and from doctors. For example negative relationships in the workplace might lead to conflict between colleagues, it is therefore important for supervisors to handle conflict within the ward/units as soon as possible and in an effective manner (Meyer et al 2009:257). An unpleasant workplace will cause employees to leave the organisation (Mokoka, Oosthuizen & Ehlers 2010:4). Work relationships can lead to stress and can influence the performance of employees (Meyer et al 2009:286).

Shortage of nurses

A shortage of nurses could also lead to stress. Stress occurs when nurses are requested to help out (float) in various patient care units that are unfamiliar to them. Meyer et al (2009:244) say that a nurse who is requested to work overtime to cover the shortage may suffer from low morale, become fatigued and dissatisfied. Fatigue might cause nurses to make errors when carrying out delegated duties, while at the same time these nurses are expected to function effectively and meet the unfamiliar patients' health needs (Yoder-Wise 2007:534).

Lack of recognition

According to the *Longman Dictionary of Contemporary English for Advanced Learners* (2009:1453), recognition refers to the act of realising and accepting that something is true or important. Mullins and Christy (2013:468) state that managers often seem not to respond to good performance of employees, but they are ready to react negatively when employees are not performing as expected.

2.3.3.3.4 Life stressors

Moorhead and Griffin (2010:175) further identify stressors that are found external to the organisation. These include life trauma and life changes such as divorce or death in the family.

- **Life change**

Life change refers to any meaningful change in a person's personal or work situation; too many life changes that occur in a short period of time might cause the person to suffer from health problems (Moorhead & Griffin 2012:188). Life changes include divorce or death in the family. Jones (2007:364) identifies other common external sources of stress including problems with weight management; substance/alcohol abuse; shift work; inability to manage time effectively; and mental disorders, such as untreated depression or anxiety.

- **Life trauma**

According to Griffin and Moorhead (2014:189), life trauma means any big change that occurs in an individual's life that alters his or her attitudes, emotions, or behaviours. Life trauma can occur because of a major threat to a person's security; it can be from natural disaster (Newstrom 2015:409).

2.3.3.3.5 Management of stress in the workplace

Kanter's Theory postulates that low stress levels are advantageous to empowering people. Having dealt with the causes and consequences of stress, means of lowering stress levels will now be discussed. According to Luthans (2011:298), strategies for stress are divided into individual coping strategies and organisational coping strategies.

- **Individual strategies for managing stress**

Exercise

Individuals can reduce their own stress levels by involving themselves in physical exercises, such as stress aerobics, walking, jogging, swimming, and riding a bicycle. The involvement in exercises has good benefits for the employee as they increase lung capacity and provide mental diversion from work pressures, thus lowering the work-related levels of stress (Robbins & Judge 2013:637). People who involve themselves in exercises experience less tension and stress and they become more confident, than people who do not participate in physical activity and tend to become depressed and to

experience negative consequences of stress such as hypertension and heart diseases (Moorhead & Griffin 2012:192).

Relaxation

Relaxation assists in reducing a person's arousal level and helps one unwind, psychologically and physiologically. Psychological relaxation promotes feelings of well-being, peacefulness, calmness and a clear sense of being in control and it reduces tension and anxiety (Gibson et al 2012:218). Other relaxation strategies that a person can utilise include soothing background music, avoidance of distracting thoughts and negative events and adopting a comfortable position in a relatively quiet place (Newstrom 2011:419).

Time management

Time management means making optimum use of the available time (Meyer et al 2009:230). Time management assists in stress reduction. In order to effectively deal with delegated tasks, the employee can put together tasks that need to be carried out by classifying them into three categories namely critical activities that must be performed, important activities that should be performed, and optimal things that can be delegated or postponed (Moorhead & Griffin 2012:192). Managers can also conduct workshops and teach employees on how to manage time in order to reduce their stress level.

- **Organisational strategies for managing stress**

In the following section strategies for managing stress are discussed. Managers can utilise the strategies to lower the stress levels of their employees and promote empowerment of employees working in their organisations.

Supportive work environment

Mullins and Christy (2013:109), suggest that it is important for managers to ensure that employees are treated with respect. Managers should create a psychologically supportive and healthy work environment. This means that treating people with

consideration, respect and trust, giving full recognition and credit, getting to know members of staff as individuals, and placing emphasis on end results could lead to reduction of stress (Mullins & Christy 2013:109).

Promotion of good work relationships

Managers should encourage good work relationships among employees in order to prevent and to minimise stress. The nursing unit manager can promote team building and teamwork by creating trust in the nursing unit through openness, honesty and respect between staff and demonstrate respect by treating the staff as professionals and adults. The creation of trust also means that the manager should take into consideration the knowledge, skills and experience of staff when delegating responsibilities (Meyer et al 2009:286).

Organisational programmes

According to Griffin and Moorhead (2014:195), organisations are also responsible for assisting employees in managing stress. These authors further suggest that managers should ensure that work schedules are designed in such a way that they do not cause stress. For example when scheduling off duties policies should be implemented in order to ensure that employees get enough time to rest (Meyer et al 2009:218). Managers should also ensure that work overload is prevented by ensuring that delegated duties are within the capabilities of the employee. When delegating tasks or activities to employees, the manager should analyse the individuals' skills levels and abilities to evaluate their capabilities to perform the various tasks and to determine characteristics that might prevent them from accepting responsibility for the task.

Creation of career development opportunities

Tyson (2015:204) states that organisations should provide career management policies and establish a committee which will focus on the identified development needs of individuals, their motivation and intentions, the opportunities available and the needs of the organisation. Organisations have the responsibility to encourage employees to become independent in managing their career development and to acquire new knowledge and skills through lifelong learning, assisting the employee to develop the

capability to maintain current employment or to seek another job if necessary (Wilton 2011:347).

A research study conducted by Wang, Kong and Chair (2011:242) on job stress levels and coping strategies employed by Hong Kong surgical nurses revealed that workload, lack of support, inadequate preparation, and conflict with other nurses were the most frequent stressors experienced by them.

The study (Wang et al 2011:242) further indicated that the three frequently used methods to cope with stress were evasiveness (avoidant activities used in coping with a situation), confrontation (confronting the situation, face up to the problem, constructive problem solving), and optimism (positive thinking, positive outlook, positive comparison).

Evasive strategy

In employing this strategy the nurses preferred to ignore the problem and not discuss it with others because they felt that this approach might help them save face and disclosing the problem to others might be viewed as the nurse's incapability. These nurses avoided discussing their problems with their supervisors because they thought that it would affect their job appraisal.

Confrontive strategy

This is a strategy which emphasised problem-solving by means of planning to keep the situation under control. The confrontive coping strategy was rated as the most effective coping strategy and its use showed correlation with reducing stress levels. This method could result in achieving better cognitive appraisal and a more positive emotional response.

Optimistic strategy

This strategy was seen as effective in dealing with nurses' job-related stress. Optimistic thinking was seen as helping the individual in maintaining a positive focus and continually making efforts to cope with difficulties at work.

In addition to the above three strategies, the following section focuses on how stress could be lowered in order to facilitate empowerment of employees in the workplace.

Social support

Social support refers to the amount of perceived helpfulness derived from social relationships. It can be derived from talking to a friend, and can comfort a person who is suffering from stress (Kreitner & Kinicki 2013:555). Social support is also used to reduce the level of stress. It includes two internal sources namely co-workers and supervisors (Seo, James & Price 2004:439). Social support can be emotional expressing concern, indicating trust, boosting esteem and listening. Social support is also seen as a network of assistance activities, interactions, and relationships that give employees the satisfaction of having their personal needs acknowledged (Newstrom 2015:418).

Kreitner and Kinicki (2013:555) divide social support into four types: **Social companionship** refers to spending time with other people in leisure and recreational activities as a means of support. **Esteem support** involves providing information which conveys the message that the person is accepted and respected despite the problems or inadequacies that have occurred. **Informational support** is evident in the assistance provided to help define and understand the problem in order to cope with the situation. **Instrumental support** entails the provision of financial aid, material resources or needed services.

Social support is also viewed as the comfort, assistance, or information a person receives through formal or informal contacts with individuals or groups (Ivancevich et al 2011:258). Social support can be effective in managing stress, and managers can be of assistance to employees suffering from stress by making them aware of the availability of external and internal social support systems. There are other support systems that employees can use in order to deal with stress such as family support, peer group support, and the support of people who once had similar problems (Marriner-Tomey 2009:44). Support groups can assist the stressed employee by spending time with the colleague and involving themselves in activities such as playing basketball. This will assist to reduce stress (Griffin & Moorhead 2014:195). Social support includes non-work support sources such as neighbours, care givers, health professionals and self-help

groups. These sources of support can assist in lowering the stress levels of employees (Ivancevich et al 2011:248).

Employee assistance programme

According to Kreitner and Kinicki (2013:560), an employee assistance programme refers to a number of programmes aimed at helping employees to deal with personal problems like substance abuse, health-related problems, family and marital problems and other issues that interfere with job performance. Ivancevich et al (2011:262) state that an employee assistance programme also assists employees who have stress-related problems. Managers can make use of the employee assistance programme by referring employees who are experiencing stress, life trauma, life change, alcohol abuse and other emotional problems for counselling. Managers could also provide information to employees about the availability of an employee assistance program and counselling programmes in order to allow members to make informed decisions.

Application to Kanter's Theory

Moorhead and Griffin (2012:180) define stress as a person's adaptive response to a stimulus that places excessive psychological or physical demands on the person. There are factors in the workplace that could lead to stress, namely task demands, physical demands, role demands and interpersonal demands (Griffin & Moorhead 2014:185). Managers should create workplace environments where sources of stress are identified and limited, and make sure that effective strategies are implemented to lower stress levels where they exist in order to empower employees to manage their own stress situations (Meyer et al 2009:279). The creation of a workplace environment that ensures that there are effective strategies to lower the stress levels in the workplace is in line with Kanter's Theory which indicates that the leader's empowerment behaviour leads to decreased levels of job tension and increased work effectiveness (Davies, Wong & Laschinger 2011:634).

2.3.3.4 Low burnout

The last dimension of the third component of Kanter's Theory on *positive work behaviours and attitudes* is low burnout. As with low stress, the concept of burnout and

its causes first need to be clarified before low burnout levels can be discussed in terms of empowerment.

2.3.3.4.1 Definition of burnout

According to the *Longman Dictionary of Contemporary English for Advanced Learners* (2009:216), burnout refers to the feeling of always being tired; the person has been working too hard. Yoder-Wise (2007:540) describes burnout as a prolonged response to chronic emotional and interpersonal stressors in the job environment. Whereas Whitehead et al (2007:224) view burnout as the progressive deterioration in work and other performances, resulting from increased difficulties in coping with high and continuing levels of job-related stress and professional frustration. The individual feels that he or she has used up all of his or her available energy to perform the job and feels that he or she does not have enough energy to complete the task. It is also a combination of physical fatigue, emotional exhaustion, and cognitive weariness which might cause the individual to reduce the number of hours worked or change to another profession or job (Sullivan 2013:320).

Burnout is a job-related condition arising as a consequence of severe distress occurring in individuals who have previously functioned at an adequate level. It is a physical, emotional and mental exhaustion syndrome which arises from chronic physical exhaustion, feelings of helplessness, hopelessness and the development of a negative self-concept as well as negative attitudes towards the profession (Gui, Barrill & While 2009:479). In clinical practice nurses may experience physical exhaustion if they are required to work overtime on a regular basis. Burnout is characterised by decreasing energy, power and resources in the presence of excessive demands (Ebrahim et al 2013:3448).

2.3.3.4.2 Sources of burnout

Burnout could arise from work overload; lack of control; insufficient reward; unfairness; breakdown of a sense of community; and value conflict (Clark 2009:77). Other sources of stress include overload, conflicting demands and family commitments (Pines 1996:42). There are four factors that are considered to be the main contributors to burnout. These factors are high levels of work overload, dead-end jobs, excessive red

tape and paperwork, and poor communication and feedback particularly regarding job performance (Gibson, Ivancevich, Donnelly & Konopaske 2012:205).

Sources of job stress as discussed in the previous section can lead to burnout. These sources include ***intrinsic factors,*** such as lack of autonomy and ***organisational variables***, such as inadequate staffing, limited financial resources, and unmanageable workload. The ***reward system*** refers to the way employees are rewarded or punished. The ***human resources system*** refers to the number and availability of opportunities for staff development, fair salary and benefits, as well as organisational policies. In addition, ***leadership*** refers to the way in which managers relate to their staff (Whitehead et al 2007:226).

Mullins and Christy (2013:716) state that organisational causes of burnout are excessive workload, lack of autonomy and authority, insufficient reward and disparity between personal and organisational values. Authority refers to line authority - the type of authority that each manager possesses, and which flows through the chain of command (McKenna & Beech 2014:67). Authority comes from the employees' expert knowledge and skills, their license, their position and their peers (Roussel 2013:232). Unrelieved stress leads to emotional exhaustion (Ivancevich et al 2008:254) and Ebrahim et al (2013:3448) considers emotional exhaustion the core element of burnout.

- **Emotional exhaustion**

Newstrom (2015:408) suggests that employees who suffer from burnout experience emotional exhaustion and feel that they are unable to effectively attend to patient needs and accomplish their professional goals such as the provision of quality nursing care to patients. Greenberg (2013:117), states that employees who experience burnout may not complete or catch up with allocated tasks or projects in time, and because they perform at unreasonably high levels they become exhausted while they strive to do more.

The individual feels that he or she has used up all of his or her available energy to perform the job and feels that he or she does not have enough energy to complete the task (Sullivan 2013:320). Persons suffering from burnout feel emotionally drained and are unable to express their feelings. They lose hope, become helpless and think that

nothing will work out for them (Pines 1996:9). Experiencing these feelings is contrary to being empowered as the individual is consumed by a sense of loss and hopelessness.

A research study conducted by Patrick and Lavery (2007:47) on burnout in nursing indicated that the number of hours worked by nurses per week is associated with emotional exhaustion and depersonalisation which indicates that working long hours is associated with high levels of burnout. Having to work overtime is another factor associated with emotional exhaustion especially for those nurses who are pressured or expected to do overtime on a regular basis as this deprives them of sufficient rest. The study by Rosales, Labrage and Rosales (2013:6) on nurses' job satisfaction and burnout supports the view that nurses' level of burnout is manifested by emotional exhaustion, depersonalisation and lack of personal accomplishment. In addition, employees who work in an overcrowded area where there are frequent interruptions and noise can experience stress which can lead to burnout (Robbins et al 2010:535).

- **Interpersonal relationships**

According to Luthans (2011:280), burnout is not seen as a problem of people themselves only, but of the social environment in which they work. Burnout creates a sense of isolation and a feeling of lost control, causing the affected employees to relate differently to others and to their work such as being judgemental about what other people do in the workplace. Burnout is associated with the caring professions (nursing, education and social work) where the practitioners are required to care and give of themselves. For example in the nursing profession there is extensive contact with patients who have different health needs and the nurse is responsible for assisting these patients in dealing with their health problems, needs and treatment. Thus a high workload, lack of social support and no or very little, administrative appreciation and support contribute to organisational burnout because an employee is tired and exposed to increased pressure and anxiety when there is a lack of administrative support in the organisation (Lumanlan 2013:24).

2.3.3.4.3 Effects of burnout

The effects of individual burnout become evident in conduct such as rudeness, criticism and insults, irrational anger and isolation, fading dedication and commitment to the

organisation, and abuse of alcohol and drugs (Clark 2009:77). According to Bagraim et al (2011:242), early signs of burnout include lack of enjoyment or involvement in one's job; inability to prioritise and manage time; complaining about the quality of work of others; and being unable to set boundaries and refusal to do more work.

2.3.3.3.4 Management of burnout

Managers should ensure that burnout is minimised in their organisations in order to achieve their goals. The following section focuses on strategies that managers can implement to reduce burnout in employees.

- **Promotion of job satisfaction**

According to Ivancevich et al (2011:153), job satisfaction is the positive attitude that workers have about their jobs. Job satisfaction may reduce the risk of experiencing burnout, and high levels of job satisfaction are seen by Rosales et al (2013:6) as a means of decreasing the levels of burnout in nurses. When nurses are provided with adequate resources such as equipment and an adequate budget; they will feel empowered. Nurses who are empowered experience less burnout and less job strain (Manojlovich 2007:3).

- **Promotion of empowerment**

Kanter's Theory indicates low burnout as the last dimension of *positive work behaviours and attitudes* and it is reckoned as a variable that could enhance empowerment. Hochwalder (2007:211), states that empowerment can be enhanced by limiting sources of burnout, by reducing role ambiguity; enhancing access to information and resources; enhancing socio-political support; and by reviewing the organisational culture. Employees with high levels of empowerment and organisational mentoring may experience lower levels of burnout and greater work satisfaction. Mentoring creates opportunities for employees to achieve their potential through clinical accompaniment and training and it facilitates professional development. For example in organisations where employees are given the opportunity to direct and control job-related activities they tend to use their own discretion in solving problems.

Another research study conducted by Cavus and Demir (2010:68) revealed that when managers put in place organisational structures that empower nurses, they promote a greater feeling of fit between nurses' expectations of their quality of work life and the organisational goals and objectives and they thus create a work environment which reduces the level of burnout. Nurses want to work for organisations which provide them with autonomy and authority to make decisions without being closely supervised.

- **Employee assistance programmes**

The employee assistance programme was discussed under stress and therefore it will briefly be applied to burnout. Nurse managers should be attentive to the wellbeing of their subordinates, find ways of eliminating sources of burnout in their organisations, by establishing employee assistance programmes and advising affected employees to go for professional counselling (Kelly 2008:645). It is important for organisations to have employee assistance programmes where employees can be counselled and supported in dealing with work and or family challenges, because unresolved challenges will influence the performance of the employee, who will not be able to function at his or her best.

- **Clear statement of tasks**

Burnout at organisational level can be lowered by giving subordinates clear instructions about tasks to be done. This will create an opportunity for the subordinate to learn and to understand his or her obligations and receive the necessary guidance in terms of expected behaviours (Mullins & Christy 2013:321). The task-related information will assist the employee to carry out delegated tasks, to feel confident and be self-directed, and negative emotions such as anxiety will be replaced with innovation and productivity because an employee is in possession of the relevant information for carrying out the job (Marriner-Tomey 2009:125).

- **Orientation programmes**

The level of burnout can also be lowered by designing and implementing an orientation programme for employees and providing on-the-job training (Ebrahim et al 2013:3448). Orientation of personnel is conducted by the organisation and by the unit manager to

promote job satisfaction and the retention of the employees; it assists the manager in introducing new employees to the organisation's policies, co-workers, and regulations. Participation of beginners to the orientation programme assists in reducing uncertainty and prevents unnecessary misunderstanding which might lead to stress and later to burnout (Marriner-Tomey 2009:364). On-the-job training refers to learning from hands-on experience and guidance by their supervisor or by another trainer (Muller et al 2011:563). Burnout can also be lowered by ensuring that there are regular team meetings during which suggestions and criticism are allowed, access to social support is available, and a participatory environment promotes team building and teamwork Ebrahim et al (2013:3448).

- **Social support**

Social support can also be used to lessen burnout in employees because it leads to psychological well-being. Social support refers to the knowledge that employees have that they are cared for, and are esteemed and valued by their network of colleagues and supervisors for emotional support. They communicate and share mutual obligations (Pines 1996:210). Support is divided into six functions, namely listening, professional appreciation, professional challenge, emotional challenge and sharing social reality. According to Pines (1996:210), employees suffering from burnout feel less supported.

- **Listening**

According to the *Longman Dictionary of Contemporary English for Advanced Learners* (2009:1233), 'listen' refers to the act of listening. In the workplace or at home people want someone to listen to what they have to say. Employees who are in crisis or faced with workplace challenges or family challenges need someone who will listen to them as they express their challenges, their pain, frustration, joy, pride and their major conflicts and not interfere or immediately give advice or judge without having understood the crisis. Listening conveys support, caring and comfort and prevents burnout because it shows the person in crisis that someone shares his or her pain (Pines 1996:210). In clinical practice it is important for managers to listen to their employees' concerns, and their work and family challenges, provide encouragement and support as far as they can and then refer them for professional counselling should it be deemed necessary.

- **Professional appreciation**

According to the *Longman Dictionary of Contemporary English for Advanced Learners* (2009:70), appreciation refers to a feeling of being grateful for something someone has done. Employees in the workplace expect professional appreciation from their supervisors. Appreciation can be in the form of positive feedback from an expert who understands the work the employee is doing. Employees who are not challenged become bored and stagnant. It is important to facilitate the growth of employees and encourage them to stretch themselves to eliminate boredom. When faced with challenges, employees need unconditional support to enable them to express their feelings related to their work (Pines 1996:210).

- **Setting of realistic goals**

Employees can reduce burnout by developing and adopting more realistic, challenging but attainable goals. Employees should be advised not to adopt difficult goals because they will find it difficult to attain them and motivation will be lowered (Kinicki & Fugate 2013:190). Setting of realistic, attainable goals assist employees to lower their self-expectations and in turn assist in lowering burnout (Ebrahim et al 2013:3448). Managers should also practise participative goal setting, which means involving employees by giving them the opportunity to exchange information which leads to empowerment (Kinicki & Fugate 2012:190).

This closes the discussion of Kanter's *Theory of Structural Empowerment* and the literature review pertaining to the third component of Kanter's Theory, namely *positive work behaviours and attitude*. Mullins and Christy (2013:107) suggest that some level of stress is necessary to motivate employees to accomplish delegated duties and to ensure that the organisation's goals are met. However Kanter's Theory stipulates low levels of stress and burnout as prerequisites for empowering employees. Too much stress is thus not good for either the employees or the organisation as it produces negative consequences such as burnout. It is important for managers to ensure that structural and psychological empowerment structures are in place in order to minimise stress levels and burnout in the workplace, thus creating an empowering environment.

A research study conducted by Jennings (2008:174) on work stress and burnout among nurses, and the role of the work environment and working conditions, revealed that managerial support and participative management helped to reduce stress. Burnout and work stress were reduced when managers created work environments that provided employees with access to opportunity, information, resources and support.

Application to Kanter's Theory

Yoder-Wise (2007:540) describes burnout as a prolonged response to chronic emotional and interpersonal stressors in the job environment. Burnout results from emotional exhaustion and sources of job stress such as lack of autonomy, inadequate staffing and resources, limited financial support and unmanageable workload (Whitehead et al 2007:226). Managers should create work environments that lower burnout in employees by ensuring that there are clear statements of task, access to social support and by setting realistic goals and conducting regular team meetings (Ebrahim et al 2013:3448). The creation of work environments that lower burnout in employees is in line with Kanter's Theory which indicates that burnout is reduced when managers create work environments that provide employees with access to opportunity, information, resources and support, thus empowering them (Jennings 2008:174).

2.4 EMPOWERMENT

Empowerment of employees is the key to the success of any organisation (Blanchard 2007:103). This study is aimed at the empowerment of nurses, and Kanter's *Theory of Structural Empowerment* was selected as the appropriate theory to base this study on. However, empowerment as a concept does not form part of the three components and 14 dimensions of this theory. It is thus considered important to consult the literature in defining and clarifying empowerment.

In order to understand empowerment as a concept, the following aspects will be dealt with: definition of empowerment, the process of empowerment, phases/levels of empowerment, effects of empowerment and the role of organisational structures in the empowerment of employees.

2.4.1 Defining empowerment

Empowerment is defined as the process of giving individuals the authority, responsibility and freedom to act on what they know and instilling in them the belief and confidence in their own ability to achieve and succeed (Huber 2010:261). Empowerment is a management practice concerned with giving front-line employees more responsibility, resources and authority, harnessing the creativity and brainpower of all employees and not of managers only, and is concerned with the proper placement of employees in order to allow them to maximise their potential in meeting the goals of the organisation (McKenna & Beech 2014:85). According to Corbally et al (2007:171), empowerment can be categorised into the following three approaches: organisational, psychological and management.

The **organisational approach** suggests that the environment in which one works determines one's capacity to be empowered. According to this approach, empowerment is seen as control over conditions that makes actions possible.

The **psychological approach** posits that a sense of meaning, self-determination, competence and impact constitute empowerment. Individuals, therefore, perceive past, present and future events within a work setting, associating them with empowerment or disempowerment.

The management approach suggests that managers should be able to identify conditions of powerlessness and then intervene, using various strategies such as participative management, goal setting, a feedback system, and job enrichment to alleviate this sense of powerlessness. Williamson (2007:133) sees empowerment as leading to increased productivity and effectiveness. It is also seen as the transmission of power in organisations to those who are less powerful (Ergeneli et al 2007:42).

Empowerment is concerned with recognising and releasing into the organisation the power that people already have in their wealth of useful knowledge, experience, and internal motivation (Kinicki & Fugate 2012:348). Kuokkanen et al (2009:117), state that in an organisation empowerment refers to encouraging and allowing individuals to take personal responsibility for improving the way they do their jobs and contribute to the organisation's goals. Employees should be allowed to take the initiative and to do what

they think is best, without fear that the supervisor is standing by to change their decisions. Empowerment is concerned with the sharing of social power in an organisation, employees share goals and combine efforts to reach those goals and this fosters creativity in the organisation's outcomes and future (Luthans 2011:325).

According to Emeritus, Brandt and Howie (2011:165), empowerment refers to those policies that share information, authority, and responsibility with the lowest ranks in the organisation. Empowerment of employees is also concerned with participative leadership; which emphasises employees' involvement in decision-making whereby managers consult with subordinates with the aim of taking their suggestions into account before making decisions (Schermerhorn et al 2012:300). Jooste (2011:229), states that empowerment refers to employees participating in policy decisions that affect them directly before the policies are implemented. In clinical practice it is important to allow employees to participate in decision-making as this leads to ownership of the decisions taken.

Robbins et al (2010:177) argue that decision-making is not for managers only, but non-managerial employees also make decisions that affect their jobs and the organisations for which they work, for example they decide how much effort to put into their work and whether to comply with a request made by the superior.

Marriner-Tomey (2009:124), says that managers can facilitate empowerment through nurturing relationships and through delegation by providing freedom that allows employees to successfully do what they want to do rather than getting them to do what the managers want them to do; and by allowing employees to participate in independent problem-solving, especially regarding problems related to their functioning at unit level. Participative decision-making can be implemented by supervisors where they work together with employees as a group during problem solving.

Marriner-Tomey (2009:124) states that empowerment also focuses on personal psychological resources which means that an employee needs to have a strong self-concept and a clear understanding of his or her strengths and weaknesses to be able to acknowledge mistakes and find solutions and to grow instead of blaming other people for his/her mistakes.

Empowering leadership plays an important role, focussing on sharing power with employees by communicating the significance of employee jobs, providing decision-making autonomy, expressing confidence in employee performance capabilities and removing barriers to performance (Kinicki & Fugate 2012:350). Empowerment makes greater use of the knowledge, skills and abilities of employees, it encourages teamwork, it aids the successful implementation of change programmes, it improves performance because of the opportunities it provides for employees to do their work more effectively, it develops an individual's knowledge and they become more willing to participate in new ways of doing things and to engage in meaningful teamwork (Mullins & Christy 2013:651). It is important for managers to create workplace environments that empower nurses to uphold professional standards and optimize knowledge and expertise (Davies, Wong & Laschinger 2011:634).

2.4.2 The process of empowerment

According to Williamson (2007:134), empowerment can be viewed as a process or an outcome. The outcomes include self-efficacy, perceived control, or improved health and wellbeing. Moorhead and Griffin (2010:482) state that empowerment is the process of enabling workers to set their own goals, make decisions, and solve problems within their sphere of responsibility and authority.

Blanchard (2007:68) states that empowerment is a process of unleashing the power in people – their knowledge, experience and motivation, thus focusing their power to achieve positive outcomes for the organisation and themselves. The process of nurse empowerment occurs when there is a linkage between "a nursing vision", structural components that involve nurse participation, and the use of a process of inquiry (Williamson 2007:135). The description of empowerment as indicated by Blanchard (2007:68) suggests that when employees are given power, they are able to utilise their knowledge and experiences in meeting patients' needs and organisational goals in a positive manner that involves determining and expanding their level of power and authority, where the leader is willing to give and the recipient is willing to take.

2.4.3 Phases/levels of empowerment

According to Burkholder (2007:1), there are six different levels, different applications, and different times and circumstances where the leader needs to use different levels of empowerment with the people he/she works with. The six levels of empowerment could form the basis for an employee development programme. The levels of empowerment are discussed according to the view of Burkholder (2007:1).

Level 1: This level is the most basic and simple level; the employee is given a task and is expected to report back to the leader with findings, upon which the leader makes a final decision. At this level in clinical practice the leader may allow the employee to learn from making mistakes to enhance the development of the employee.

Level 2: At level 2, the employee is slightly empowered; the employee not only carries out the task but is allowed to make recommendations based on the task and findings. The manager still holds the power and authority to make the final decision, but the employee has been allowed to make some inputs into the decision. At this level, the leader comes to understand what the employee is capable of, to understand how the employee thinks and works, and to appreciate what his/her decision-making processes are. The employee is now able to take more responsibility and ownership in his/her work.

Level 3: At this level, the employee is given authority to make decisions in view of the delegated task, but the leader still retains the power and authority to approve or disapprove of the decision. The leader, however, has to indicate to the employee when the feedback is due, by providing clear expectations.

Level 4: At this level, empowerment implies approval of whatever decision the employee has made. At this level there is no waiting for the leader's decision but the employee must know or ask if the allocated task is not clear. Here the employee is truly empowered as the leader has given decision-making powers and authority to the employee. At this level, the employee has mastered the knowledge and skills of providing nursing care. The leader turns responsibility for day-to-day decision-making and problem solving to the employee (Blanchard 2007:91).

Level 5: At this level, employees feel that they have earned the trust of the leader and are able to work on their own and take full responsibility and ownership, not only of specific tasks or projects, but of their entire role within the organisation.

Level 6: At this level, the leader allows the employees to be on their own. The employee is given the power and authority to do what is deemed necessary to accomplish the goals of the department or the organisation. At this level, employees accept the risk for their decisions, no one is watching over their shoulders to make sure that they are making the right decision. This level is very uncomfortable for the employee because the employee is on his/her own. The job of the leader now is to empower the employees by allowing and trusting them to act independently and to acknowledge the employees' excellent performance and provide the appropriate resources the employees require to carry out their nursing duties (Blanchard 2007:91).

The empowerment levels described above imply that empowerment is a process, progressing from one level to the next. However, every employee is unique, with different capabilities and skills, not all can be expected to reach the highest level of empowerment. But for those who can, the feeling of autonomy in their work environment, accompanied by a sense of self-actualisation, is possible.

- **Powerlessness**

According to Finkelman and Kenner (2013:495), powerlessness refers to the feeling that one cannot make a difference or have an impact on a situation or is not listened to. Chandler (1986:7) defines powerlessness as the experience of not having control over conditions that make action possible. Powerlessness means that employees lack control over management policy, immediate work processes, or conditions of employment (Mullins & Christy 2013:279).

Newstrom (2015:206) states that powerlessness contributes to the feeling of low self-efficacy; employees feel that they cannot successfully perform their jobs or make meaningful contributions. Finkelman and Kenner (2013:495) are of the opinion that employees who are experiencing powerlessness feel that they are not listened to or that they are not viewed positively, they cannot make an impact in clinical settings, and they are not sought out for their opinion.

Newstrom (2015:206) maintains that powerlessness may also arise from having to work under an authoritarian leader, or from a reward system that fails to reinforce competence or innovation, or in a job that does not have variety, discretion and role clarity. Lord and Hutchison (1993:2) asserts that powerlessness at the individual level can be viewed as the expectation of the person that his/her own actions will not be effective in influencing the outcome of life events. Lord and Hutchison (1993:2) further identify two types of powerlessness namely real powerlessness and surplus powerlessness. Real powerlessness results from economic inequities and oppressive control exercised by systems and other people, while surplus powerlessness is an internalised belief that change cannot occur, a belief that is seen as apathy and an unwillingness of the person to struggle for more control and influence.

According to Chandler (1986:33), nurses who experience powerlessness have a different response to work than those who have access to power structures. Chandler (1986) conducted a research study on the relationship of nursing work environments to empowerment and powerlessness.

From the research study Chandler (1986:33) identified the following behavioural responses to powerlessness:

- The powerless supervisor exhibited the tendency of doing work activities himself/herself and blocking subordinates' development
- The powerless supervisor becomes more rigid, and directive
- They become oppressive, and influence other people by relying on persuasive power which uses coercive approaches.

To illustrate the effect of powerlessness on the professional conduct and behaviour of nurse managers and registered nurses, Chandler's (1986:5) model was derived from the nursing model of Martha Rogers. This model was used to explain the effects of powerlessness on the work behaviour of employees in the workplace as contained in Table 2.2.

Table 2.2 The effects of empowerment versus that of powerlessness

Effects of powerlessness	**Work behaviour**
1 If the individual perceives that he/she does not have access to opportunity and power the individual perceives work conditions as: • controlled • rules oriented • coercive authority, and • dominant leadership.	1 The individual who experiences powerlessness may express the following work behaviours: • low aspiration • low motivation • disengagement • cautiousness • conservatism • low risk taking • low self-esteem • burnout and • turnover
Effects of empowerment	**Work behaviour**
2 If a person perceives that he/she has access to opportunity and power then the individual perceives work conditions as: • flexible • decentralised • persuasive authority • bureaucratic leadership and • expansive	2 The individual who experiences being empowered would express work behaviours such as: • High aspiration • achievement oriented • Commitment • Innovative • change maker • risk taking • Visibility • high self-esteem • investment and • satisfaction

(Adapted from Chandler 1985:5)

The following section will focus on the impact of empowerment and powerlessness on the professional conduct and behaviour of nurse managers and registered nurses. Finkelman and Kenner (2013:98) state that nurses want and need power to influence decision-making and have an impact on issues that matter.

Table 2.3 The impact of empowerment and powerlessness on the professional conduct of nurses

Empowered nurses	Nurses who are not empowered
1 Image: • Nurses who feel empowered feel that they are respected and trusted to be active participants, they convey a positive image to other health team members, patients, to the public and to their families (Finkelman & Kenner 2013:98).	1 Image: • Nurses who do not feel empowered will not display a positive image. Nurses who are not empowered will also not be able to communicate in a professional manner (Finkelman & Kenner 2013:9).
2 Performance teams: • Empowered nurses feel a responsibility for the team's performance and activities, these nurses contribute to improving care and reducing errors (Finkelman & Kenner 2013:98).	2 Performance teams: • Performance teams can experience powerlessness if they do not know the purpose and goals of their tasks and when their roles are not clear (Marriner-Tomey 2009:375).
3 Control over the content of nursing practice • Nurses have power to act on what they know, that is the ability to act according to one's knowledge and judgement, this is known as the control that the nurse has over the content of nursing practice. This relates to bedside nursing where the nurse is closest to the patient, can fully assess the patient's cues and trends as they arise and provide individualised nursing for that patient based on the empowerment which is acquired through knowledge and skill and a feeling of autonomy (Manojlovich 2007:4).	3 Control over the content of nursing practice • In the case of experiencing powerlessness relative to organisational administrators and medical staff, nurses in nursing practice are usually unable to use their professional preparation in view of autonomous decision-taking and for implementing independent decision-making (Manojlovich 2007:4).
4 Maintaining competence in nursing practice: • Nurses are able to maintain power though knowledge development, which is acquired through education and expertise, autonomy and power, and has its foundation in educational preparation (Manojlovich 2007:4).	4 Maintaining competence in nursing practice: • Powerlessness of nurses may occur due to feelings of being less well educated than other groups within the hospital which places them at a disadvantage in organisational politics (Manojlovich 2007:4). For example, a health care professional who accesses fewer resources for client care, and has to compete with other health care team members, such as pharmacists, laboratory technicians, and dieticians

Empowered nurses	Nurses who are not empowered
	for scarce resources, often encounter conflict situations with other health team workers (Hood 2014:101).
5 The nurse's role in patient advocacy • Mature nurses tend to be bold and more assertive in advocating for patients because they have been practising for a long time and they know the culture of the institution well enough to know how to act when faced with work challenges and are able to challenge decisions made by other professionals (Meyer et al 2009:87).	5 The nurse's role in patient advocacy • Younger nurses are afraid to challenge the system because they lack self-confidence to challenge decisions made by other health care practitioners; they cannot trust their own judgement yet (Meyer et al 2009:87).
6 Responsibility: • Allocation of responsibility to employees at lower organisational levels can be used to develop successful practitioners; employees who share a sense of higher accountability are likely to be more proactive and they can take risks and learn from their mistakes (Abraiz et al 2012:395).	6 Responsibility*:* • Employees who are less empowered, lack a strong sense of responsibility, illustrate distrust and are reluctant to take risks (Abraiz et al 2012:395).

2.4.4 Lack of empowerment/disempowerment

Empowerment is seen as something positive or highly desirable to be aspired to, advocated for, or to be attained (Kelly 2008:264). Nurses who are empowered, participate actively in trying to get what they want. Their involvement will make them feel powerful, even if their efforts are not always successful (Kelly 2008:260).

Nurses who lack power or the ability to act, experience feelings of frustration and failure (Manojlovich 2007:3). Disempowered nurses need to put in more effort, energy and time to adapt to the pressure of job insecurity - energy that could rather be used for working towards the achievement of goals (Stander & Rothmann 2010:2). According to Paynton (2008:2), nurses experience dissatisfaction in their professional roles and are frustrated by the formal powerlessness they sometimes experience in their positions when **formal constraints** jeopardise quality patient care.

The qualitative study conducted by Kai, Beaven, Faull, Dodson, Gill and Beighton (2007:26) on professional uncertainty and disempowerment responding to **ethnic**

diversity in healthcare settings revealed that professionals experienced disempowerment and felt helpless when working with patients of different ethnicity, because they lacked cultural expertise and restrained themselves in the process of gathering information from patients about their culture.

Nurses who were involved in the study conducted by Kai et al (2007:26) voiced disempowerment about intercultural interactions that they had with their patients. Nurses found it difficult to question their patients about their cultural values and their cultural practices. The understanding of the values and cultural practices of patients is important in nursing practice because it forms part of the comprehensive nursing care of patients. Lack of understanding of the values and cultures of patients contributed to the disempowerment of nurses because it was not possible for them to provide quality patient care due to the lack of cultural expertise.

In a research study conducted by Bradbury-Jones, Sambrook and Ivine (2007:346) on the meaning of empowerment for nursing students, a critical incident study indicates that students experienced disempowerment in relation to learning in nursing practice due to reasons such as the **absence of mentors** and lack of continuity of support from mentors. When mentors were off from work students had to be allocated to other mentors and for this to be done the students had to be moved to other areas of placement. Students experienced disempowerment as the result of lack of **continuity in learning**, lack of information sharing about the change of the teaching and learning schedule in advance, and the change of the learning environment. The students also felt disempowered in the new areas of placement because they were not welcomed in the new work teams, they felt excluded and treated insensitively by other team members.

The following organisational factors were identified by Ning et al (2009:2646) as causes of lack of empowerment or disempowerment in nurses: lack of access to resources, and of opportunities to attend in-service training sessions and workshops to update their skills. This meant that they had **limited opportunities to gain more knowledge** that could be applied in nursing practice. In addition, decisions related to patient care were made by physicians and nurse managers, but nurses who provided direct nursing care had no say in decisions about patient care. The ability to act independently was

therefore very limited. Finally, there was little opportunity for nurses to form alliances with other professionals.

These findings on the causes of lack of empowerment are supported by Blanchard (2007:138), who postulates that lack of empowerment arises from a lack of opportunities for development, lack of authority to do one's work, and lack of recognition.

The study conducted by Bradbury-Jones et al (2007:346) on lack of empowerment/disempowerment indicates that it is important for nurse managers and supervisors to provide continuous support by giving clear goals and objectives. The research study further indicates the importance of the promotion of teamwork among employees in order to prevent exclusion of team members due to insensitivity, feelings of being unable to make a difference and feelings of not being welcomed by team members.

The next section focuses on the effects of powerlessness on the professional conduct of nurses based on the research of Ning et al (2009:2646). The following factors **were identified as reasons for powerlessness in nurses**:

- **Lack of opportunities for development**

The research conducted by Richards and Potgieter (2010:45) on the perceptions of registered nurses in four state health institutions on continuing education indicates that there are barriers to opportunities for staff development. These barriers include difficulty in paying course fees; lack of staff development plans; policies and procedures that limit nurses from getting study leave; and lack of time due to family responsibilities**.**

Structural barriers such as shortage of staff, lack of knowledge about learning opportunities and the lack of a supportive environment make it difficult for nurses to develop themselves (Richards & Potgieter 2010:45). Employees have the right to be developed; this means that managers are expected to implement *The Skills Development Act no 97 of 1998* in their organisations to ensure that employees are given the opportunity to develop themselves professionally and personally by offering

development programmes to equip nurses to provide the required nursing care to patients.

- **Lack of involvement in decision-making**

The lack of involvement of nurses in formal decision-making involving patient care, leads to powerlessness (Paynton 2008:1). For example, nurses should be involved in the development of policies that deal with patient care (Shariff & Potgieter 2012:2) Their research study on the extent of East African nurse leaders' participation in health policy development indicates that nurse leaders are not involved in national policy development. The role of nurses in the health policy development process is limited. Nurses' participation mainly occurs in the implementation stage. Powerless managers may display the following symptoms: They supervise too closely, fail to train subordinates and are inclined to do the job themselves (Gibson 2014:342).

- **Lack of resources**

The lack of access to resources contributes to feelings of disempowerment among nurses. Nurses become powerless if they are unable to acquire the resources they need to accomplish their job-related tasks. These resources include the financial means, material, and supplies required to do the job (Laschinger et al 2009:229). Lack of resources increases workload and the amount of effort exerted at work. A research study of Mokoka et al (2010:5) indicated that a shortage of supplies and sometimes dysfunctional or lacking equipment made it impossible for nurses to function effectively. The lack of adequate resources leads to powerlessness.

There are, however, organisations that are characterised by easy access to information, resources, support, learning and development opportunities for employees, which facilitate satisfaction among their employees (Willem, Buelens & De Jonghe 2007:1013). Employees may feel that when the organisation provides them with the necessary supplies for getting the work done their work is valued and they feel that they are rewarded for their efforts (Kluska, Lachinger & Kerr 2004:123). Managers are expected to equip hospitals with the necessary resources in order to enhance the quality of patient care and the employees' level of job satisfaction.

- **Lack of authority to do one's work**

The authority referred to, is the individuals' right to make decisions without approval by higher management and to expect obedience from others (Ivancevich et al 2008:485). It also enables the subordinate to issue valid instructions for others to follow (Mullins & Christy 2013:642). In clinical practice, many managers are accustomed to making decisions and resist delegating authority to their subordinates, thus depriving the latter of learning opportunities (Ivancevich et al 2008:486). Lack of authority induces job insecurity that leads to strain for the nurse. Disempowered individuals have to put in special effort, energy and time to adapt to the pressures of job insecurity, and their energy cannot be used for working towards achieving organisational goals, whereas empowered nurses have reduced levels of emotional strain (Stander & Rothmann 2010:3). Managers should not retain authority that cripples the delegate's ability to accomplish the task, setting the individual up for failure, and minimising efficiency and productivity (Sullivan 2013:132).

Application to Kanter's Theory

No application to Kanter's Theory was done because empowerment as a concept does not form part of the three components of Kanter's *Theory of Structural Empowerment.* The concept of empowerment was included in this study in order to clarify what empowerment is and what it entails.

2.4.5 Organisational structures

Generally, organisations are **c**omprised of groups of people such as leaders, managers and employees who are employed to perform certain functions. It is therefore necessary to consider the different types of organisational structures and their means of communication and decision-making patterns in view of providing opportunities for enabling the process of empowerment. It is important to explain the meaning of organisational structure. According to Huber (2010:401), an organisational structure is defined as the arrangement of the parts within a larger whole. Jones (2007:43) defines a structure as the arrangement of the work groups within the organisation that is intended to support the organisation's survival and success. The organisational structure determines who has accountability and responsibility, who makes the

decisions and who has authority and oversight of workers. Ivancevich et al (2008:449) view an organisational structure as a relatively stable relationship that supports the processes of the organisation.

Kanter's Theory focuses on the empowerment of employees. Organisational structure as a concept does not form part of Kanter's *Theory of Structural Empowerment*. However, Lucas et al (2008:965) state that organisational structures provide employees with the power to accomplish tasks. In addition, Bagraim et al (2011:6) observe that an organisational structure impacts on the way power is distributed, decisions are made, information is distributed and how employees respond to the needs of both internal and external customers. It is therefore considered important to briefly look at the influence of organisational structure on the empowerment of employees.

In order to create a specific organisational structure, certain aspects need to be considered, such as who will report to whom, how many levels of managers should there be and how much decision-making power will/can be delegated.

Finkelman (2012:107) identifies two types of organisational structure in terms of height namely tall and flat structures. To illustrate the differences between tall and flat structures the following examples are briefly discussed.

- **Tall structure**

A tall structure is defined as a structure that has a narrow span of control and with a large number of levels of authority (Mullins & Christy 2013:788). A tall structure is also referred to as a centralised, bureaucratic structure (Roussel 2013:226). Moorhead and Griffin (2012:453) describe centralisation as a structural policy in which decision-making authority is concentrated at the top of the organisational hierarchy. Willem et al (2007:1013) confirm the view of Moorhead and Griffin (2010:453) that centralisation is the extent to which the decision-making power is concentrated at top management level in the organisation.

A tall structure consists of a manager with few subordinates who function under one manager and the manager reports to one supervisor. In this structure work responsibilities are delegated to subordinates by the supervisor and subordinates are

given written directives on how to accomplish tasks (Grohar-Murray & Langan 2011:133).

The tall or centralised structure has many layers of departments and specialisation of labour. This type of structure has both advantages and disadvantages. The advantage is that managers have a narrow span of control over their employees. However, the disadvantage is that communication tends to be slow and there is a delay in decision-making, due to the many layers of people that decision-making must pass through to get to the top administrative level. The delay in decision-making leads to autocratic leadership, as decisions must go through many layers to the top of the organisation or the higher-level supervisor (Jones 2007:50). Figure 2.1 shows the solid lines by which authority, communication and decision-making power are cascaded downwards in a bureaucratic organisation. Each person has some power and authority over a few people, such as two or three people. This structure may lead to lack of empowerment of nurses because nurses might not be able to receive the information that they need in order to accomplish their delegated tasks, and have limited power to control their work responsibilities.

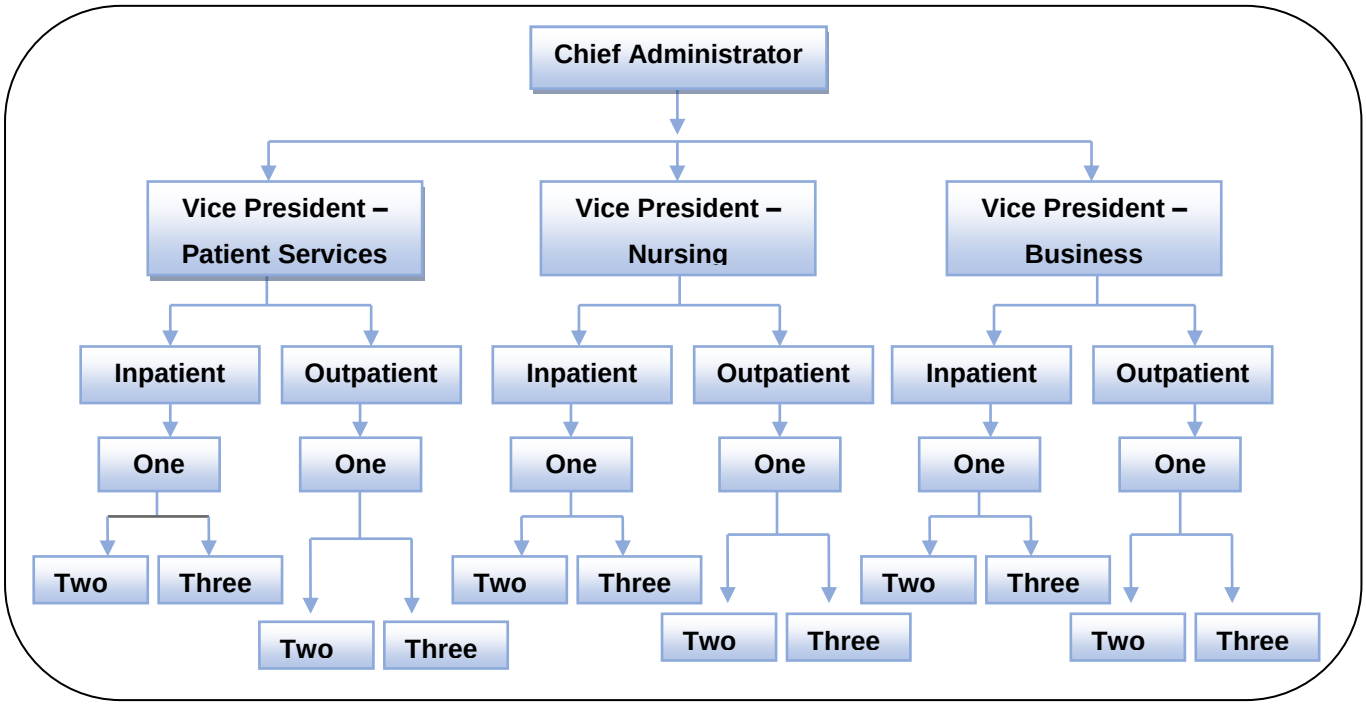

Figure 2.1 Bureaucratic structure

(Adopted from Jones 2007:50)

- **Flat or horizontal structure**

A horizontal structure refers to departmentalisation of functions; this structure uses decentralised decision-making (Finkelman 2012:107). A flat structure is also called a horizontal and participatory structure (Rousell 2013:228). Decentralisation refers to a structural policy in which decisions are made throughout the hierarchy (Moorhead & Griffin 2012:453). A decentralised organisational structure enhances employee autonomy and increases an employee's job satisfaction. However, a disadvantage is its broad span of control resulting in managers often finding it difficult to process information quickly and efficiently for the employees.

Roussel and Swansburg (2009:197) state that decentralisation results in increased morale, job satisfaction and greater motivation among managers because lower level staff members are given the opportunity to control their work environment and activities. Personnel development, flexibility, and effective decision-making is increased; conflict is decreased; the workforce is stabilised and becomes more effective and efficient; performance standards are clear; employee recognition occurs and accountability is enforced at all times (Roussel & Swansburg 2009:197). Organisations who use a decentralised structure, allow problems to be solved at the level at which they occur (Marquis & Huston 2012:265). When power is decentralised employees are allowed to participate freely in the process of decision-making, this contributes to their feeling of satisfaction since it leads them to believe that they can have some important effects on their organisations (Greenberg 2013:158).

A flat structure as illustrated in Figure 2.2 enhances employee morale and confidence because managers practise a democratic approach such as an open-door policy and two-way communication (Marriner-Tomey 2009:278). A flat structure contributes to structural empowerment because it facilitates communication, autonomous decision-making and the use of different skills which lead to staff development (Grohar-Murray & Langan 2011:133).

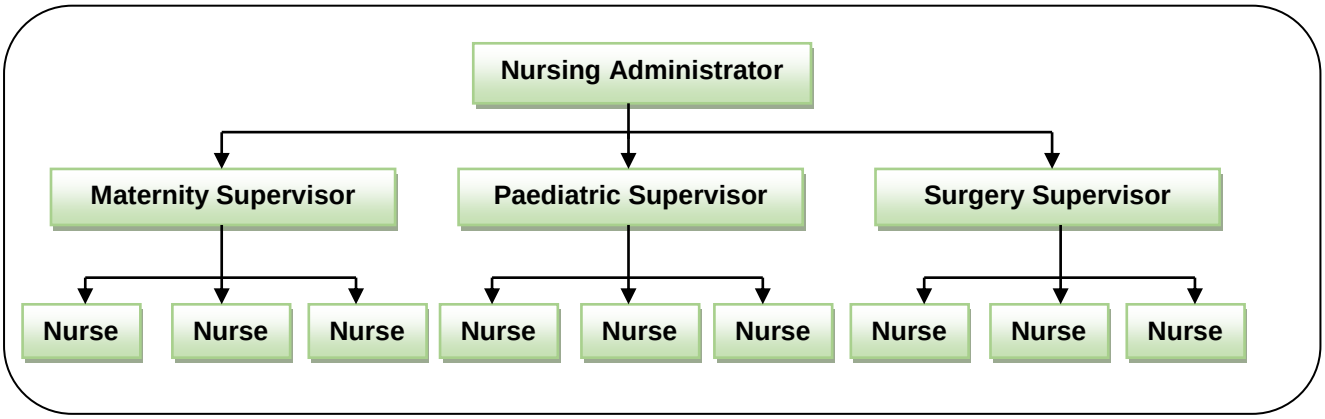

Figure 2.2 Decentralised structure

(Adopted from Jones 2007:50)

Line of authority

According to McKenna and Beech (2014:67), line of authority refers to the type of authority that each manager possesses, and it flows through the chain of command and it indicates to whom each staff member reports up through the chain of command. For example, supervisors of nursing units would report to the nursing service manager, managers of nursing units would report to the unit supervisor; and unit nursing staff would report to the nursing unit manager. Robbins et al (2010:432) state that authority is the rights inherent in a managerial position such as giving orders and expecting the subordinates to implement the orders. Managers are given authority to act in order to facilitate coordination and in order to meet their organisation's responsibilities. In nursing practice, managers and supervisors of nursing units should delegate sufficient authority to employees to enable them to carry out their assigned responsibilities according to their post levels. Line managers have authority and responsibility for all matters and activities within their own departments (Mullins &Christy 2013:524).

- **Chain of command**

According to the *Longman Dictionary of Contemporary English for Advanced Learners* (2009:70), chain of command refers to a system in an organisation by which decisions are made and passed from people at the top of the organisation to people lower down, such as subordinates. According to Robbins et al (2010:432), the chain of command refers to the unbroken line of authority that extends from the top of the organisation to

the lowest level of the organisation and clarifies who reports to whom. For example the unit nursing manager can inform the nurse about unacceptable performance or behaviour in the nursing unit. The unit nursing manager should be able to institute disciplinary measures against his/her subordinates, and could also inform employees about their rights of initiating a grievance process when aggrieved (Meyer et al 2009:307).

- **Staff authority**

According to Grohar-Murray and Langan (2011:132), staff authority refers to staff that function in an advisory capacity to give assistance to line managers. Jooste (2011:116) says staff authority is a consultative or advisory process, in which people with a staff function provide line managers with varying types of expert help and advice. The staff authority cannot force other staff members to follow his/her advice, but can make recommendations for line authority to act upon; for example the expert can advise the nursing unit manager on how to control infection in a surgical nursing unit.

- **Span of control**

The span of control refers to the number of employees who report to a manager or a supervisor. Supervisors responsible for many individuals have a wide span of control, whereas those responsible for fewer are said to have a narrow span of control (Greenberg 2013:405). A narrow span of control indicates that it has a tall structure resulting in each manager having only a few employees in the reporting structure (Jones 2007:43).

Sullivan (2013:13) states that the span of control refers to the number of employees that can be effectively supervised by a single manager. Grohar-Murray and Lagan (2011:124) argue that there are guidelines that determine the size of span of control in terms of the number of subordinates that a supervisor can direct and coordinate effectively. The supervisor is also responsible for the actions of subordinates. If the supervisor has few immediate subordinates it may result in over supervision, and too many will result in under- supervision. Empowerment can facilitate the reduction of the number of layers of management at middle management level and help bring about a

wider span of control with managers needing to exercise less control and provide supportive management.

The application to Kanter's Theory

Kanter's Theory was not applied to organisational structure because organisational structure as a concept does not form part of Kanter's *Theory of Structural Empowerment.*

2.5 CONCLUSION

This chapter looked at the theoretical framework on which the research was based. The chosen theoretical framework is Kanter's *Theory of Structural Empowerment.* The theory is divided into three components, namely: *structural empowerment* that includes the dimensions of opportunity, information, support, resources, formal power and informal power. Component two is concerned with *psychological empowerment* that includes the following aspects: meaning, confidence, autonomy and impact. Component three is concerned with *positive work behaviours and attitudes* which include the dimensions of job satisfaction, commitment, low stress and low burnout. The dilemma sprouting from the dimension of "confidence" (contained in Kanter's Theory) that subsequent researchers changed to "competence" was discussed and explained, referring to various sources. The behaviours of employees are often dependent on the structural conditions they face in the work setting.

This chapter also focused on literature that addressed empowerment as a concept and process. The aim was to define and understand what empowerment means and entails, and to identify, by means of the literature, the reasons for lack of empowerment in registered nurses and to determine how empowerment can be enhanced in order to cultivate confident nurse leaders. The literature review also explored the influence of organisational structure on the empowerment of employees as decision-making powers, inter alia, differ in the different organisational structures. Key concepts of the study were identified and explained in order to facilitate understanding.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

The term research methodology refers to the development, testing and evaluation of research instruments and methods (Brink et al 2012:214). The purpose of this chapter is to discuss the study design and research method by which the purpose and objectives of the study can be achieved. These include the research design, validity of the research design, population and sampling, data collection, validity and reliability of the measurement instrument, pre-testing of the measurement instrument, data analysis, ethical principles, and permission to conduct the study.

3.2 PURPOSE OF THE STUDY

The purpose of the study was to

Determine what empowerment encompasses, and to establish the reasons for the perceived lack of empowerment of registered nurses. Furthermore, to develop empowerment guidelines which managers can apply in order to enhance the empowerment of registered nurses in their service, and in turn cultivate confident nurse leaders.

3.3 OBJECTIVES OF THE STUDY

The objectives of the study were to

- describe what empowerment entails, and its effect on professional conduct in the workplace
- explore the level of empowerment among nurse managers and registered nurses
- ascertain the effect of powerlessness on the professional conduct and behaviour of nurse managers and registered nurses

- establish the reasons for the perceived lack of empowerment among nurse managers and registered nurses.
- determine if there is a difference in the way in which nurse managers and registered nurses perceive the existing empowerment in their public hospitals
- develop empowerment guidelines for nurse managers and registered nurses

3.4 RESEARCH METHOD

The study was conducted in two phases, phase 1 focussed on the quantitative descriptive study. In phase 2 guidelines were developed with the aim of improving the empowerment of nurse managers and registered nurses.

3.4.1 Research design

A research design is an overall approach to the study grounded in a set of beliefs about knowledge, and a question that must be answered (Houser 2008:183). It also refers to a plan, structure and strategy of investigation to answer the research question (Basavanthappa 2007:164). In this study, a quantitative research approach with an exploratory and descriptive design was used.

3.4.1.1 Quantitative research design

According to Polit and Beck (2012:739), quantitative research pertains to the investigation of phenomena that lend themselves to precise measurement and quantification, often involving a rigorous and controlled design. Empirical evidence, “evidence which is rooted in the objective reality and which is gathered directly or indirectly through the senses rather than through personal beliefs or hunches” provides the data for quantitative research.

The quantitative approach lends itself to a systematic plan of action for obtaining answers to the question being studied and for handling some of the difficulties encountered during the research process (Polit & Beck 2008:66). Usually the information gathered is numerical in nature and results from formal measurement which is analysed by means of statistical procedures (Polit & Beck (2012:14). Quantitative research design refers to the use of statistics with the aim to process and explain data

and to summarise findings. It is concerned with systematic measurement and statistical analysis (Fox & Bayat 2007:7).

3.4.1.2 Exploratory design

Exploratory studies are undertaken to explore and to describe a phenomenon of interest in order to generate new knowledge (Houser 2015:475). The interest of conducting such a study could come from the lack of information about the new situation or the new area of interest (De Vos et al 2011:95). Exploratory research investigates the full nature of the phenomenon, the manner in which it is manifested, and other factors which are related to the topic (Polit & Beck 2008:20).

Exploratory design refers to the development of an initial understanding of a phenomenon to answer the question why certain actions are carried out (De Vos et al 2011:96). This understanding was generated by the literature review and enhanced by the data gathered from the respondents. In this study, the exploratory design was used to explore the level of empowerment among nurse managers and registered nurses, to ascertain the effect of powerlessness on the professional conduct and behaviour of nurse managers and registered nurses and to establish the reasons for the perceived lack of empowerment among nurse managers and registered nurses.

3.4.1.3 Descriptive design

According to Polit and Beck (2012:226), researchers applying the descriptive design observe, describe, and document aspects of information as it naturally occurs with an aim of describing the phenomenon. Quantitative description focuses on the prevalence, incidence, and measurable attributes of a phenomenon (Polit & Beck 2008:275). Fox and Bayat's (2007:8) view is that a descriptive design aims at highlighting current issues or problems through a process of data collection to enable the researcher to describe the situation more completely. This method is suitable in situations where the researcher believes that no information yet exists to solve the problem. In descriptive research the researcher has to examine the situation, collect the data, analyse and interpret the data, and reach a satisfactory solution.

Descriptive design refers to a study in which the phenomenon is described, or the relationship between variables is examined with no attempt to determine the cause-and-effect (Brink et al 2012:211). In this study, the descriptive design was used to describe what empowerment entails, ascertain the effect of powerlessness on the professional conduct and behaviour of nurse managers and registered nurses, establish reasons for the perceived lack of empowerment among nurse managers and registered nurses and to develop empowerment guidelines for nurse managers and registered nurses.

3.4.2 Validity of the research design

Validity refers to approximate reality as closely as possible (Du Plooy 2009:28). Validity also refers to a measure of whether a data collection tool accurately measures what it is supposed to measure (Moule & Goodman 2014:466). Internal and external validity are relevant to the research design.

3.4.2.1 Internal validity

Internal validity is concerned with the inferences regarding the existence of an empirical relationship. The researcher's responsibility is to develop strategies to rule out factors other than the presumed cause that could have accounted for the observed relationship (Polit & Beck 2008:287).

Internal validity refers to the fact that there are no errors internal to the design of the research project. This means that the researcher can state with certainty that the differences in the results are entirely due to the experimental treatment or situation within the research context.

Internal validity refers to the degree to which the outcome of an experiment can be attributed to the manipulation of the independent variable (Brink et al 2012:109). As this study was not experimental in nature, the researcher did not manipulate variables during the research study (Fox & Bayat 2007:79).

3.4.2.2 External validity

According to De Vos et al (2011:153), external validity refers to the degree to which results can be generalised to the whole population. Polit and Beck (2008:287) state that external validity is validity that is concerned with inferences about observed relationships that will hold over variations in persons, settings, time, or measures of the outcome. LoBiondo and Haber (2010:578) refer to external validity as the degree to which findings of a study can be generalised to other populations or environments. In this study, the research results were not generalised to other settings that did not take part in the study.

3.5 POPULATION

A population is all possible units of analysis (Du Plooy 2009:108). A population is also defined as the entire set of individuals or objects having some common characteristics (Polit & Beck 2008:761), for instance, a population might consist of all the hospital records on file in a particular hospital (Polit & Beck 2008:338). The population for this study is divided into two components namely the site and respondent populations.

3.5.1 Site population

The study was aimed at the public hospitals of the Mpumalanga Province. Mpumalanga Province is divided into the following three districts: Ehlanzeni, with eight public hospitals; Nkangala, with 11 public hospitals; and Gert Sibande, with nine public hospitals. The total number of public hospitals in the Mpumalanga Province is thus 28. The site population for this study consisted of the three districts of the Mpumalanga Province.

3.5.2 Respondent population

Respondents are individuals who respond to questioning in a survey (Du Plooy 2009:96). In this study, all respondents were registered nurses. However, two categories of registered nurses formed the respondent population for this study. The first category of respondents was nurse managers (155) who formed Group A. According to Mellish et al (2010:79), a nurse manager is a trained registered person

who forms an essential part of the health team. In this study, a nurse manager is an individual who coordinates actions and allocates resources in a unit or department to achieve organisational goals (Kelly & Marthaler 2011:48).

The second category of respondents was registered nurses totalling 729, who were included as Group B. Mellish et al (2010:127) define a registered nurse as a person who is granted professional freedom to make independent professional decisions about the care he/she provides to his/her patients. In addition, this person is qualified and competent to independently practice comprehensive nursing in this manner, and to the level prescribed, and who is capable of assuming responsibility for such practice (South Africa 2005:25). In this study, registered nurses are seen as competent and independent persons who are able to provide comprehensive nursing care.
Nurse managers and registered nurses were included in the study to ascertain how the different aspects noted in objective 2, 3, and 4 affected these two groups of respondents, consequently the data analysis involved a comparison of outcomes between the nurse manager and registered nurses on certain aspects.

3.6 SAMPLING

Sampling refers to the process of selecting members from a specific population of a defined population, with the intent that the sample accurately represents that population (Gall, Gall & Borg 2007:652). There are two basic sampling approaches in quantitative research; these are probability sampling and non-probability sampling (Brink et al 2012:134).

A sample is a subset of the population that is selected to represent the population (Brink et al 2012:217), and to participate in a study (Polit & Beck 2008:765). The sample size refers to the mathematical calculation of the sampling error that could result from using a given sample size and a given sampling procedure (Waltz, Strickland & Lenz 2010:215). The sample size depends on the size of the population, the homogeneity of the population and the degree of reliability required in the investigation, and the method of sampling (Fox & Bayat 2007:61).

3.6.1 Sampling technique

Sampling technique refers to the process of selecting a portion of the designated population to represent the entire population (Basavanthappa 2007:194). Sampling techniques include probability (or random) sampling and non-random sampling. Random sampling, also known as probability sampling, involves drawing a portion, or sample of a population, so that each member of the population has an equal chance of being selected (De Vos et al 2011:226). In this study, random sampling was used for the site selection.

- **Site sampling**

Site sampling was carried out by using the simple random sampling technique. The site sample frame consisted of the three districts within the Mpumalanga Province. Random selection of a district was carried out in the following way: the districts were numbered as follows: District 1, District 2 and District 3. These labels were placed in a hat and one was randomly selected. The site selected to participate in the study was District 1 (Ehlanzeni District). District 1 has eight hospitals. These hospitals were identified as hospitals A, B, C, D, E, F, G and H. All eight hospitals in District 1 participated in the study.

- **Respondent selection**

The total registered nurse population of District 1 namely nurse managers and registered nurses were divided into two groups. The researcher visited each selected hospital. On arrival at each hospital the researcher, explained the purpose of the visit to the nursing service managers in charge of hospitals and requested permission to visit each nursing unit in order to be able to recruit the respondents for the study. After acquiring permission the researcher utilised allocation lists to count the number of nurse managers and registered nurses who were on day duty, night duty, day off, sick leave, annual leave and on maternity leave in order to establish the number of the respondents who could participate in the study. The inclusion criteria for this study were that the respondent had to be a registered nurse working as a nurse manager or registered nurse in one of the eight public hospitals in the Ehlanzeni District, Mpumalanga.

No respondent sampling was carried out, as all nurse managers (155) and registered nurses (729) working in the eight public hospitals of the selected district were requested to participate in the study. Thus, a census was conducted. A census refers to the inclusion of every member of the population in the study (Du Plooy 2009:108).

The number of respondents in each hospital in Ehlanzeni district is indicated in Table 3.1

Table 3.1 Number of nurse managers and registered nurses in hospitals of District 1

Categories of nurses	Hospital A	Hospital B	Hospital C	Hospital D	Hospital E	Hospital F	Hospital G	Hospital H	Total
Nurse managers	12	28	52	7	18	19	9	10	155
Registered nurses	66	84	170	30	80	170	73	56	729
Total	**78**	**112**	**222**	**37**	**98**	**189**	**82**	**66**	**884**

3.7 DATA COLLECTION

Data collection refers to data gathering using the questions of who, what, how, when and where it is to be collected (Gall et al 2007:395). The researcher collected data from nurse managers and registered nurses by means of a structured questionnaire (refer to Annexure A).

3.7.1 Data collection instrument

The questionnaire was used as the data collection instrument. A questionnaire is a list of questions compiled by a researcher on a specific topic to which answers are required and about which information needs to be given. Questionnaires are more cost effective than interviews, their content is easy to analyse and they are less intrusive than telephone or face-to-face surveys (Fox & Bayat 2007:88). However, the questionnaire also has a number of disadvantages. The disadvantages of questionnaires include the lack of opportunity for the respondents to be able to ask for an explanation if the

question is not clear, and the researcher cannot request the respondents to expand or to illustrate their answers (Parahoo 2014:293).

According to Kumar (2011:149), the disadvantages of questionnaires include low response rate because the respondents might fail to return questionnaires, or the topic might not be of interest to the respondents, the questionnaire is limited to a study population that is able to read and write, there is a possibility for the respondents to consult with each other with the aim of reaching some consensus pertaining to the answers.

3.7.1.1 Development of the questionnaire

One questionnaire was used for both groups, and was developed by the researcher in English. The reason for making the questionnaire available in English only, is that nurse managers and registered nurses were educated and trained in English, thus assuming they would understand the questions.

The development of the questionnaire was based on the literature review as discussed in Chapter 2 and on Kanter's *Theory of Structural Empowerment.*

The questionnaire consisted of open-ended and closed-ended questions. An open-ended question is a question that does not restrict the answers of respondents to pre-established alternatives (Polit & Beck 2008:760). A closed-ended question is a question containing specific, mutually exclusive response categories, from which respondents must select a category that best fits their answer or responses (Fox & Bayat 2007:91).

A Likert scale was used to measure the views of the respondents in terms of the questions or statements posed. Houser (2008:279) states that a Likert scale is a measurement scale that uses attitude statements ranked on a five or seven-point scale. The degree of agreement or disagreement is given a numerical value, hence a total can be calculated. According to the scale that ranged from 1 to 5, 1 = strongly disagree (SD), 2 = disagree (D), 3 = neutral (N), 4 = agree (A), and 5 = strongly agree (SA).

The questionnaire was divided into seven sections A to G:

Section A: Items relating to biographic information of the respondents.

For sections B to F the respondents were required to use a five-point Likert scale.

Section B: Questions relating to empowerment
Section C: Questions relating to structural empowerment
Section D: Questions relating to psychological empowerment
Section E: Questions relating to work behaviours and attitudes
Section F: Questions relating to organisational structure
Section G: Open-ended questions on aspects of empowerment listed below:

1. What challenges/problems do you experience regarding your decision-making role in your organisation?
2. What kind of assistance do you receive from your supervisor regarding delegated tasks?
3. Indicate the most important barriers to your performance in the organisation.
4. Indicate any resources which might enhance the performance of your allocated duties.
5. How do you assist your supervisor to make job-related decisions?
6. Why do you feel that the nurses are overloaded/not overloaded with work in your ward?
7. How do you exert authority to control your job-related duties?

3.7.2 Validity and reliability of the data collection instrument

It is important for the researcher to ensure that the questions included in the questionnaire are clear and understandable to the respondents in the way intended by the researcher. The answers provided by the respondents must also be understood by the researcher (Saunders et al 2012:429). The following section deals with the validity and reliability of the data collection instrument and the Content Validity Index of the measuring instrument.

- **Validity**

Validity refers to the ability of an instrument to consistently measure what it is supposed to measure (Houser 2008:254). There are four common types of validity, namely: content validity, face validity, criterion-related validity and construct validity (De Vos et al 2011:173).

Criterion-related validity**:** Criterion-related validity refers to the degree to which scores on an instrument are correlated with some external criterion (Polit & Beck 2012:724). Criterion-related validity is measured with a correlation coefficient (Vogt 2007:119).

Construct validity**:** Construct validity refers to the extent to which the measurement of questions actually measures the presence of those constructs that they are intended to measure (Saunders et al 2012:668). Construct validity is based on statistical procedures (Kumar 2011:180).

Content validity refers to the representativeness, or sampling adequacy of the content items of an instrument. It focuses on whether the full content of a conceptual definition is represented in the measure (De Vos et al 2011:173).

Face validity refers to content validity which makes use of the opinion of experts to evaluate the accuracy of an instrument (LoBiondo-Wood & Haber 2010:578). Face validity also refers to an aspect of validity that examines whether the item on the scale, on the face of it, reads as if it indeed measures what it is supposed to measure (Sekaran & Bougie 2013:394).

In this study, content and face validity are relevant. In establishing content (and face) validity, three processes were followed, firstly seven experienced practitioners perused the questions, there after a Content Validity Index was done using five different professional nurses and thirdly, a pre-test was done with respondents similar to those of the actual study. These processes will now be discussed.

In determining **content validity** the instrument is presented to a group of experts in the field of study for their assessment of the validity of the content of the instrument; experts are requested to evaluate each item contained in the instrument in line with the degree

to which the variable to be tested is presented. The experts do however not perform statistical measurements in judging content validity (Brink et al 2012:166). The researcher conducted a literature review in order to ensure content validity as the formulation of questions was based on the studied literature. Key concepts were identified and were used in the formulation of questions. After the development of the data collection instrument the researcher requested people trained in a specialised field of nursing research or who have been active in nursing research for a number of years, or in nursing practice and who have undertaken research, to check the validity of the questionnaire.

As an example of how content validity can be tested, LoBiondo-Wood and Haber (2010:289) give the following explanation: content validity was assessed by means of psychometric properties which consisted of a 32-item medication adherence scale that was designed to measure factors influencing adherence to the prescribed medication regimen for patients with heart failure; content validity was achieved by having the instrument reviewed by four experts in the field of heart failure. Grove et al (2013:394) state that at least five experts are recommended for judging the content validity.

During the development of the research instrument, content and **face validity** was assessed to ascertain whether the instrument contained the important items to measure the concepts to be tested, and to evaluate whether the items in the scale appeared to be relevant, clear and unambiguous (Gerrish & Lacey 2010:372). In this study content and face validity was simultaneously assessed by the following experts: the statistician, the study supervisor and the co-supervisor from the Department of Health Studies at UNISA, as well as four nurse educators.

According to Sullivan (2013:41), managers perform the following functions: they are accountable for the efficient accomplishment of organisational goals, coordinate the organisation's activities through planning, organising, supervising, staffing, evaluating, negotiating, representing, and they also use their interpersonal skills, authority, responsibility, accountability and power as defined by the organisation. The researcher chose the four nurse educators because of their knowledge and skills in performing management functions and because they have acquired experience in their different fields of work enabling them to assess the content validity of the questionnaire. The experts were provided with the proposal of the research study and the framework of

Kanter's *Theory of Structural Empowerment* so that they could evaluate the content of the questionnaire.

The experts were requested to indicate in writing the questions that they felt were not clear and to also indicate their inputs in writing in order for the researcher to improve the content of the data collection instrument.

The experts gave inputs on the questionnaire; they highlighted changes in the phrasing of certain questions, for example question 6.3.2 and 6.3.3 'my supervisor listens to my concerns and considers my suggestions'; the input for this question was that the question contained two variables and the experts suggested that it be separated into two questions to ensure validity of the response. Other feedback indicated that the researcher should include blocks for data capturing, some of the questions had no sub-headings reflecting the dimension under which the questions were asked and the researcher was advised to arrange questions according to the dimensions of Kanter's *Theory of Structural Empowerment,* and to separate the concepts of empowerment and organisational structure from the dimensions of Kanter's *Theory of Structural Empowerment,* because the two concepts do not form part of the theory. The suggested inputs were implemented in order to improve the data collection instrument.

In addition to making the suggested amendments as indicated by the seven practitioners noted above, a Content Validity Index was performed using the five experts who were representatives from the relevant population but not part of the actual study. They included three nurse managers, one nurse educator and one registered nurse who are skilled in nursing research and in clinical practice. They were requested to complete a Content Validity Index as a further measure to ensure validity of the data collection instrument. The following section focuses on the Content Validity Index (CVI) of the measuring instrument.

The Content Validity Index

In performing the Content Validity Index the five experts were requested to rate each item contained in the questionnaire for relevance using a 4-point scale.

According to Lynn (in Grove et al 2013:395), content validity index refers to the score calculated for the entire instrument (Grove et al 2013:395). The Content Validity Index is a calculation that provides the researcher with more evidence to be confident that the instrument truly reflects the desired concepts or constructs (LoBiondo-Wood & Haber 2010:576).

According to Polit and Beck (2008:459), the Content Validity Index is measured by using a 4-point scale, namely 1 = not relevant, 2 somewhat relevant, 3 = quite relevant, 4 = highly relevant. When evaluating the Content Validity Index of the instrument, the researcher is expected to use experts in order to evaluate and to rate each item according to the scale provided based on the relevance of an item. Lynn (in Grove et al 2013:396) explains that 'the Content Validity Index for each scale item is the proportion of experts who rate the item as a 3 or 4 on a 4-point scale'. The number of 3 and 4 responses are then added and divided by the number of experts to provide a figure in the form of a fraction or a total of 1 if the question is highly relevant (Lynn in Grove et al 2013:396).

After obtaining the ratings from the experts, all items for each dimension were analysed separately in order to evaluate the validity of the item. Thereafter the content validity index was analysed and calculated (Annexure E).
The following section deals with the results of the Content Validity Index pertaining to the measuring instrument. A summary of the results will be provided as Annexure E which contains the detail of the CVI.

- **Empowerment**: Four of the five items were rated relevant by all five experts, one item (5.1 policy formulation) was rated highly relevant by four of the five experts giving a relevance rating of 1 for items testing empowerment (5/5=1).

- **Structural empowerment:** includes the following dimensions of

    - Opportunity

        Four of the five items were rated highly relevant by all five experts, one item (6.1.2 coaching about tasks or function) was rated highly relevant by four of

the five experts giving a relevance rating of 1 for items testing opportunity (5/5=1).

- Information

Four of the six items were rated highly relevant by all five experts, two items 6.2.1 giving inputs in issues that relate to tasks/responsibilities and 6.2.2 regular feedback were rated highly relevant by four of the five experts giving a relevance rating of 1 for items testing information (5/5=1).

- Support

Four of the five items were rated highly relevant by all five experts, one item (6.3.3 my supervisor considers suggestions) was rated highly relevant by four experts giving a relevance rating of 1 for items testing support (5/5=1).

- Resources

All five items were rated relevant by all five experts, two items 6.4.2 provision of equipment necessary to execute allocated tasks and 6.4.3 operational budget were rated highly relevant by four experts giving a relevance rating of 1 for items testing resources (5/5=1).

- Formal power

All five items were rated highly relevant by all five experts giving a relevance rating of 1 for items testing formal power (5/5=1).

- Informal power

All five items were rated highly relevant by all five experts, one item (6.6.1 sponsors for seminars) was rated highly relevant by four experts giving a relevance rating of 1 for items testing informal power (5/5=1).

- **Psychological empowerment:** Psychological empowerment includes the following dimensions:

  - Meaning

    Three of the five items were rated highly relevant by all five experts, two items 7.1.3 expression of beliefs and values and 7.1.4 competent in the execution of duties were rated highly relevant by four experts giving a relevance rating of 1 for items testing informal power (5/5=1).

  - Competence

    Five of the six items were rated highly relevant by all five experts, one item (7.2.5 tasks that are not covered by the scope of practice) was rated highly relevant by four experts giving a relevance rating of 1 for items testing informal competence (5/5=1).

  - Autonomy

    All five items were rated highly relevant by all five experts giving a relevance rating of 1 for items testing autonomy power (5/5=1).

  - Impact

    Four of the five items were rated highly relevant by all five experts, one item (7.4.2 provision of feedback) was rated highly relevant by four experts giving a relevance rating of 1 for items testing impact (5/5=1).

- **Positive work behaviours and attitudes**

  - Job satisfaction

One of the five items was rated highly relevant by five experts, two items 8.1.1 fair salary and 8.1.2 work climate were rated highly relevant by four experts giving a relevance rating of 0.80 for items testing job satisfaction (4/5=0.80).

- Commitment

  Three of the five items were rated highly relevant by five experts, one item (8.2.5 preparing for promotion) was rated highly relevant by four experts giving a relevance rating 1 for items testing commitment (5/5=1).

- Low stress

  Three of the five items were rated highly relevant by all five experts, one item (8.3.3 lifelong learning) was rated highly relevant by four experts giving a relevance rating of 1 for items testing commitment (5/5=1).

- Low burnout

  Three of the five items were rated highly relevant by all five experts, item 8.4.2 time to effectively attend to patients needs and 8.4.5 authority to control job-related tasks were rated relevant by three experts giving a relevance rating of 1 for items testing low burnout (5/5=1).

- **Open-ended questions**

  - Question 1

  The experts rated question 1 as highly relevant by giving a relevance rating of 1 for the question the testing decision-making role (5/5=1).

  - Question 2

  Four of the five experts rated question 2 relevant giving a relevance rating 0.80 for the question testing the kind of assistance received (4/5=0.80).

- Question 3

Four of the five experts rated question 3 relevant giving a relevance rating of 0.80 for the question testing the important barriers to performance in the organisation (4/5=0.80).

- Question 4

All five experts rated question 4 highly relevant giving a relevance rating of 1 for item testing, giving resources which might enhance the performance a relevance rating (5/5=1).

- Question 5

All five experts rated question 5 highly relevant giving a relevance rating of 1 for the question testing job-related decision-making (5/5=1).

- Question 6

All five experts rated question 6 highly relevant giving a relevance rating of 1 for the question testing the work load in the nursing units (5/5=1).

- Question 7

All five experts rated question 7 highly relevant giving a relevance rating of 1 for the question testing the authority to control job related duties in the nursing units (5/5=1).

- **Organisational structure**

Three of the five items were rated highly relevant by all five experts, two items 9.3 more than 15 subordinates and 9.5 the right to initiate a grievance process were rated highly relevant by four of the five experts giving a relevance rating of 1 for items testing organisational structure (5/5=1).

The total score on the CVI should all dimensions acquire a relevant score, is 91. The total number of items which were found to be valid was added together and a score of 89 was obtained. The content validity index for the measuring instrument was thus found to be 90/91 = 0.99. This score indicates that the items were deemed to be valid in terms of content.

- **Reliability**

Reliability refers to the ability of a measuring instrument to yield consistent numerical results each time it is applied (De Vos et al 2011:177). Reliability means the ability of a research instrument to provide similar results when used repeatedly under similar conditions. Reliability indicates accuracy, stability, and predictability of a research instrument; the higher the reliability, the higher is the accuracy of the instrument (Kumar 2011:396). In this study, a set of questions was used to acquire information from registered nurses on the different aspects of empowerment. A correlation coefficient in the form of Cronbach's Alpha was used to measure the reliability of the empowerment constructs. Cronbach's Alpha coefficient is used to test internal consistency (Brink et al 2012:170).

According to Saunders et al (2012:668), correlation coefficient refers to a number between -1 and +1 which represents the strength of the relationship between two numerical values. A value of +1 indicates a perfect positive correlation, and a value of -1 indicates a perfect negative correlation. A correlation coefficient ranging between +1 and -1 indicates a weaker positive or negative correlation between these figures depending on its direction, and a value of 0 means that the variables are perfectly independent.

Table 3.2 Chronbach's Alpha values and interpretation

Cronbach's values	**Interpretation**
0.80 and above	Good reliability
0.70 and above	Acceptable reliability
0.60 and above	Average reliability
Less than 0.60	Poor unacceptable reliability

This table is based on Sekaran and Bougie's (2013:293) work.

According to Sekaran and Bougie (2013:293), a reliability score of less than 0.60 is considered to be poor, those that are 0.70 are considered to have an acceptable level of reliability, and those that are above 0.80 are considered to have good reliability.

Table 3.3 indicates the level of reliability acquired for the questions pertaining to each of the 14 dimensions of Kanter's *Theory of Structural Empowerment*, plus the concept of empowerment and organisational structure as identified in the literature, thus resulting in 16 dimensions. In this study the reliability estimates ranged from 0.92 for impact which denotes good reliability to 0.67 for low burnout which denotes acceptable reliability.

Table 3.3 Cronbach's Alpha coefficient estimates for the dimensions contained in the questionnaire (Empowerment, Kanter's 14 dimensions plus organisational structure)

Dimensions	Items	Items left out	Cronbach's Alpha	Reliability
Empowerment	Q5.1 - Q5.5	None	0.76	Acceptable
Opportunity	Q6.1.1 - Q6.1.5	None	0.79	Acceptable
Information	Q6.2.1 - Q6.2.5	None	0.84	Good
Support	Q6.3.1 - Q6.3.5	None	0.86	Good
Resources	Q6.4.1 - Q6.4.5	Q6.4.5	0.72	Acceptable *problematic question for supervisors
Formal power	Q6.5.1 - Q6.5.5	None	0.77	Acceptable
Informal power	Q6.6.1 - Q6.6.5	Q6.6.1	0.77	Acceptable
Meaning	Q7.1.1 - Q7.1.5	Q7.1.4, Q7.1.5	0.87	Good
Confidence	Q7.2.1 - Q7.2.6	Q7.2.5, Q7.2.6	0.85	Good
Autonomy	Q7.3.1 - Q7.3.5	Q7.3.5	0.76	Acceptable
Impact	Q7.4.1 - Q7.4.5	None	0.92	Good
Job satisfaction	Q8.1.1-Q8.1.5	Q8.1.5	0.47	Unacceptable * problem question
Commitment	Q8.2.1 - Q8.2.5	Q8.2.4, Q8.2.5	0.86	Good
Low stress	Q8.3.1 - Q8.3.6	Q8.3.2	0.78	Acceptable

Dimensions	Items	Items left out	Cronbach's Alpha	Reliability
Low burnout	Q8.4.1 - Q8.4.6	None	0.67	Acceptable
Organisational structure	Q9.1 - Q9.5	Q9.3	0.68	Acceptable

Maigemu and Hassan (2015:186) state that all Cronbach Alpha coefficients above 0.60 are considered to be good enough for item reliability. Whereas LoBiondo-Wood and Haber (2010:295) suggest that for an instrument to be considered reliable, a level of 0.70 or higher represents an acceptable level of reliability, and that the interpretation of the reliability coefficient also depends on the proposed purpose of the measure. According to Hair et al (2011:235), a reliability of 0.70 is considered the minimum for item reliability even though lower coefficients may be considered acceptable depending on the research objectives.

All the estimates of internal consistency in Table 3.3 as measured by Cronbach's Alpha exceeded 0.60, except for the dimension of job satisfaction. The asterisks (*) in Table 3.3 under job satisfaction indicates that no construct score could be calculated for job satisfaction because the measurements of the individual questions of this dimension were found to be unreliable. This means that none of the five items on job satisfaction reliably tested job satisfaction. Table 3.3 also indicates an asterisk (*) under resources, meaning that this item was found not to be reliable as it did not relate to resources. In this study all items which scored 0.60 were considered to be reliable at an acceptable level.

3.8 PRE-TESTING OF THE INSTRUMENT

The data collection instrument was developed by the researcher based on the literature review conducted in Chapter 2 of this study. It was necessary to pre-test the instrument as it is always desirable to pilot the instrument before administering a self-completion questionnaire or interview schedule to your sample (Bryman 2008:247). The researcher can conduct a pilot study before the actual data collection is carried out. A pilot study is a procedure for testing and validating an instrument by administering it to a small group of respondents from the intended test population. The respondents who participate in the pilot study should not participate in the main inquiry (De Vos et al 2011:237). Some

researchers do not carry out the entire pilot study but only do a pre-test of the data collection instrument (Brink et al 2012:57).

A pre-test refers to the trial administration of a newly developed instrument to identify flaws (Polit & Beck 2008:762). Aspects such as accuracy, clarity of questions and consistency of responses, inadequate time limits and appropriateness of questions are important to note. Pre-testing is done by using a small sample of respondents with characteristics similar to those of the respondents of the target population (Hair Celsi, Money, Somuel, & Page 2011:267).

A pre-test was done in this study. The researcher pre-tested the questionnaire with respondents who were representative of the target population, but who were not part of the study population. Ten questionnaires were distributed to registered nurses to complete. Five questionnaires were given to nurse managers and five were given to registered nurses. The pre-test was carried out in a hospital in the Nkangala District within the Mpumalanga Province.

In applying the pre-test the researcher explained the purpose and content of the questionnaire verbally to the ten respondents during the distribution of the questionnaire. The researcher made the respondents aware of the information stipulated in the covering letter of the data collection instrument (Annexure A) and the information contained in the informed consent form (Annexure D). The informed consent was explained to the respondents to allow the respondents to make an informed decision whether to participate in the pre-test or not.

The researcher thereafter communicated with the respondents telephonically to determine if they needed some clarification in relation to the questions. The respondents indicated that they had no problems or uncertainties with the content and meaning of the questions. The respondents did not report any challenges experienced or identified any flaws in the questionnaire. The researcher probed the respondents about each part of the questionnaire from the instructions and scaling to the format and wording in order to ensure that each question was relevant, clearly worded and to ensure that questions were not ambiguous (Hair et al 2011:267). Nine questionnaires were returned, four questionnaires from nurse managers and five from registered nurses.

The completed questionnaires were checked for flaws or any misunderstanding of questions. Two of the nurse manager respondents did not answer question one on the challenges/ problems they had about their role in decision-making. One registered nurse did not answer question six on whether nurses were overloaded/not overloaded with work. No changes were effected on the instrument after the pre-test. The telephonic communication between the researcher and the respondents assisted the researcher in confirming that the pre-test respondents did not have any trouble in understanding the questions. These respondents contributed in confirming the validity of the questionnaire, and it was noted that the questionnaire could be completed within 30 minutes.

3.9 DATA COLLECTION AND MANAGEMENT

After completing the pre-test, the researcher started with the distribution of the questionnaires to the eight selected hospitals participating in the actual study.

A questionnaire distribution schedule for the different hospitals was used to ensure that the researcher had enough time to visit each of the eight hospitals and each nursing unit in the respective hospitals in order to meet all the respondents and to explain why the study was conducted, and to discuss the information that was included in the covering letter of the data collection instrument (Annexure A) and the information contained in the informed consent form (Annexure D).

When arriving at each of the hospitals on appointment, the researcher reported to the nursing service manager of the institution indicating the reason for the visit, and handed over the letter of permission from the Mpumalanga Department of Health Ethics Committee which granted the researcher permission to conduct the study. The researcher was then allowed to visit the nursing units. On arrival in the nursing units the researcher met the unit managers; and explained the reason for the visit and indicated that permission had been granted to conduct the study, giving each manager the permission letter to read.

After receiving permission from unit managers, the nursing unit allocation lists were used to identify and invite the respondents to participate in the study. The researcher

distributed the questionnaires personally to nurse managers and registered nurses who were on duty and available at that time. The questionnaires and consent letters for the respondents who were not available due to being day off, on night duty, annual leave sick leave or maternity leave were given to the unit managers who were requested to distribute them to the respondents as soon as they became available. The consent forms and questionnaires were kept separately. The respondents were informed about the area where a sealed container with an opening (similar in appearance to a tender box), was located, and were requested not to hand over their completed questionnaires and consent forms to any other person, but to personally deposit the completed questionnaires and consent forms separately in the identified box.

During the distribution of the questionnaires the researcher verbally explained to the respondents who were available at that time that participation was voluntary and that they might withdraw from the study at any time without any penalty. The researcher emphasised that all the information would be treated in confidence and would serve no purpose other than an academic one.

The researcher requested the potential respondents not to discuss the content of the questionnaires and their answers with their family members, colleagues, relatives or friends and not to request any other person to complete the questionnaire for them. This information was verbally given to the respondents and to nursing unit managers during the distribution of the questionnaires. This was necessary as Grove et al (2013:527), confirm that family members might not agree to the respondents' participation in the study or they might not understand the study process. As a result, family members or other nurses might influence the respondents' responses to the questions, or respondents might ask family members or friends to complete the questionnaire. The respondents might also discuss the questions with other people who happened to be in the room with them and the data recorded would then not reflect the respondents' own perceptions or views.

In this study the respondents were informed by the researcher that it would take approximately 30 minutes to complete the questionnaire. The researcher gave the respondents two months to complete and submit their questionnaires as stipulated in the informed consent letter (Annexure D).

Thereafter respondents were given an informed consent form to sign. The researcher gave the respondents who were available during their spare time an opportunity to complete their questionnaires. The respondents were also assured that their names and the names of their hospitals were not required on the questionnaire. Subsequently, the researcher communicated with the unit managers telephonically to determine if the respondents needed any clarification in relation to the questions, and requested unit managers to assist by reminding the respondents to complete the questionnaires. The information given to unit managers included the data collection instrument (Annexure A) and information on informed consent (Annexure D).

As the return of completed questionnaires was slow and unsatisfactory, the researcher communicated telephonically with the unit managers on several occasions, requesting that the respondents be reminded to submit their questionnaires. In addition, the researcher visited one selected hospital that was not very far from her workplace with the aim of encouraging the respondents to complete and submit their questionnaires. Despite the researcher's numerous efforts to increase the return of completed questionnaires, the response remained poor.

- **Data management**

The researcher is expected to manage data collected from the respondents in order to categorise and present the data so that interpretation can take place.

Moule and Goodman (2014:42), state that the researcher should keep collected data in a safe place. Data management means storage, access and preservation of data produced from a given investigation, and it includes the following: the entire life cycle of the data, from planning the investigation to conducting, from backing up data as it is created and used to long-term preservation of data deliverables after the research investigation has concluded (URL: http://guides.library.tamu.edu//DataManagement). The Protection of Personal Information Act 4 of 2013, stipulates that a responsible party should secure the integrity and confidentiality of personal information in his or her possession under his or her control by taking appropriate, reasonable, technical and organisational measures to prevent loss of, damage to or unauthorised destruction of personal information and unlawful access to or processing of personal information (South Africa 2013:32).

The information provided on paper or video tape should be stored in locked fireproof cabinets (Moule & Goodman 2014:69). The research data should be stored for 5-10 years, but sometimes could be kept for three years only, especially data collected by a student for study purposes such as obtaining a Master's degree (Moule & Goodman 2014:69). During the collection of data from each hospital, each container was sealed to prevent the loss of completed questionnaires. Since data capturing and analysis, all completed questionnaires have been kept in a tightly sealed container in a locked cupboard and the data will be kept for at least five years. Currently the data is in a secure place that is known to the researcher only.

- **Data coding**

The following section focuses on the coding of the questionnaire, both the closed-ended and open-ended questions that were used by the researcher to collect data from the respondents.

According to *Longman Dictionary of Contemporary English for Advanced Learners* (2009:313), coding refers to a system of marking something with letters, symbols so that facts about it can be understood by someone who knows the system. Hair et al (2011:297) state that coding refers to a number assigned to a particular response so that the answer can be put into a data base. Whereas Polit and Beck (2012:463) indicate that coding is the process of transforming raw data into a standardised form of data processing and analysis. In quantitative research coding means the process of attaching numbers to categories (Polit & Beck 2008:749).

Data should be coded in order to assist the researcher to analyse, interpret and to draw conclusions on the responses of the respondents (Moule & Goodman 2014:456). In this study all the questionnaires handed to the respondents were coded by the researcher. Letters of the alphabets were used to code the hospitals instead of using their names to ensure the anonymity of the hospitals and of the respondents, after which the questionnaires were numbered before data capturing took place. Open-ended questions were studied and coded before data analysis was conducted by the researcher. The data was captured by Statistical Consulting Services in 2013. The statistician did the verification of data with the statistical package SAS JMP software package. The SAS

JMP software package focuses on experimental or exploratory data analysis and visualisation (Kari 2015:1).

The questionnaire was divided into seven sections. Section A contained biographical information of the respondents. The nominal measurement was used to code section A. A nominal scale refers to the lowest level of measurement involving the assignment of characteristics into categories (Polit & Beck 2012:735). In a nominal scale the numbers are allocated to objects, individuals, or events only to distinguish one from the other (Fox & Bayat 2007:128).

In question 1 for position (rank), a 1 was assigned to Group A (nurse manager) and a 2 was assigned to Group B (registered nurse). In question 2 for current position of the respondents, a 1-5 scale was used. For question 3 on gender, a 1 was assigned to male and a 2 was assigned to female. For question 4, the age category, a 1-8 scale was used.

Another scale that the researcher used to classify the content of the measurement instrument is the Likert scale. A Likert scale refers to a composite measure of attitudes involving the summation of scores on a set of items where respondents rate their degree of agreement or disagreement (Polit & Beck 2012:735). Responses to items or statements believed to represent the concept being measured can be quantified by means of a Likert scale. Some of these statements about the concept being measured are positive while others may be negative, thus allowing respondents to discriminate in their responses (Parahoo 2014:289-290). The respondents are normally requested to choose from an odd number of responses, usually five, including a neutral one. The responses in a Likert scale include the following: “strongly disagree”, “disagree”, “neutral”, “agree”, and “strongly agree”.

Section B contained questions relating to the empowerment concept. In section C to section E of the questionnaire, questions were posed in accordance with the dimensions of Kanter’s *Theory of Structural Empowerment.* Section F included questions on the concept of organisational structure.

Section G included open-ended questions. In section G the questions were numbered from 1 to 7. The researcher read through the responses to the open-ended questions in

order to identify common words, phrases and other types of patterns in the responses (Hair et al 2011:297). The researcher manually analysed all the recoded data collected from the open questions. This enabled the identification of data with similar content. After reading the responses of questions, common words and similar information were grouped and recorded. The responses were added together in order to calculate the total number of the respondents who gave similar answers. Frequency and percentages were used to quantify the responses which shared similar meaning on a specific question. Thereafter data was interpreted according to the dimensions Kanter's Theory of structural empowerment. Empowerment and organisational structure were coded as concepts.

3.10 DATA ANALYSIS

Data collected from the two groups of respondents was analysed in order to explore the level of empowerment of the nurse managers and that of the registered nurses, and to reach conclusions about the findings of the study. Data analysis entails categorising, ordering, manipulating and summarising the data and describing them in meaningful terms (Brink et al 2012:177). In this study, descriptive and inferential statistics, frequencies and percentages were used to analyse and summarise the collected data.

3.10.1 Descriptive statistics

Descriptive statistics are numbers of results from a research study that are mathematically summarised for the sole purpose of representing the research variables in an understandable way (Houser 2008:362). In this study, data was analysed by means of frequency distribution. Frequency distribution refers to the number of times that a result occurs (Brink et al 2012:180). Data was also analysed by means of central tendency. Central tendency refers to finding the mean, median and mode (Grove et al 2013:53). The measures of central tendency are statistics, or numbers expressing the most typical or average scores in a distribution (Brink et al 2012:185). In this study frequencies and percentages in the form of tables and graphs were used to present the data, which will be discussed in the next chapter.

3.10.2 Inferential statistical technique

The term ‘inferential statistics’ refers to the use of sample data to make an inference about the population of the study at hand from a smaller sample (Brink et al 2012:179). In this study, data was analysed by means of the Analysis of Variance (ANOVA) to compare the different constructs. Analysis of Variance is an extension of the t-test, which permits the researcher to compare more than two means simultaneously. ANOVA is used to assess the statistical differences between the means of two or more groups (Hair et al 2011:336). In this study, the views of nurse managers and registered nurses were analysed by means of an ANOVA test in order to find out whether their views differ with regard to the empowerment aspects (Brink et al 2012:191).

3.11 ACQUIRING PERMISSION

The researcher requested permission in writing from various authorities to conduct the study. The researcher had to gain the necessary approval from the organisations that would give access to respondents (Houser 2008:82). Written permission to conduct the study was requested from the Mpumalanga Province Department of Health Research Ethics Committee (Annexure B1) after ethical clearance was acquired from the Higher Degrees Committee of the Department of Health Studies at UNISA (Certificate no HSHDC/117/2012, Annexure C1). The researcher requested permission in writing from nurse managers of selected hospitals for them to participate in the study after receiving permission from the Mpumalanga Province Department of Health Research Ethics Committee (Annexure B2 – B10). Permission was also obtained from the nurse managers of the selected hospitals (Annexure C3 – C10).

The following documents accompanied the written request for permission: the research proposal, data collection instrument (Annexure A) and ethical clearance (Certificate no HSHDC/117/2012, Annexure C1). The researcher received a letter of approval to conduct the study, dated 4 February 2013, from the Mpumalanga Provincial Department of Health Research and Ethics Committee (Annexure C2).

3.12 ETHICAL PRINCIPLES

When a research study is conducted, it is important for the researcher to take note of the ethical principles that guide research to ensure safe research practices. The researcher is expected to safeguard the rights of the respondents, the institution and the specific study field to ensure their safety. The researcher is further expected to conduct the research in an ethical manner, from the conceptualisation and planning phases, through the implementation phase, to the dissemination of results (Brink et al 2012:32). There are three fundamental ethical principles that guide researchers namely, respect for persons, beneficence and justice (Brink et al 2012:34).

The researcher considered the following ethical principles which are relevant to this study:

- **The principle of respect**

The principle of respect means that persons have the right to *self-determination* and freedom to participate or not to participate (Grove et al 2013:162). This principle means that the researcher should acknowledge a person's right to hold views, to make choices and to take actions based on personal values (Armstrong et al 2013:144). The principle of respect also indicates that people have the right to self-determination and to treatment as *autonomous* agents, meaning that they have the freedom to make choices or not to participate in research. People with diminished autonomy need to be protected (LoBiondo-Wood & Haber 2010:250). The researcher informed the respondents about the proposed study and allowed them to voluntarily choose to participate or not (Grove et al 2013:164). The *informed consent* gave the respondents the freedom to choose whether they wanted to participate in the study, or alternatively, to withdraw from the study at any time.

Before participating in the research, respondents have the right to informed consent. Informed consent means that a participant voluntarily agrees to participate in a research study in which he/she has full understanding of the study before the study begins (Brink et al 2012:213). Informed consent means that there is a process of agreement from the respondents to participate in a research study, based on the information given (Moule & Goodman 2014: 458). Informed consent information exchange between the researcher

and the respondent includes verbal dialogue, presentation of written materials, questions and answers, and agreement which is documented by a signature (Houser 2015:55). In this study the respondents were not coerced to participate but were given time to decide whether to participate in the study or not (LoBiondo-Wood & Haber 2010:255).

- **The principle of beneficence**

According to Brink et al (2012:35), researchers are expected to *secure the well-being* of the respondents. Whereas Grove et al (2013:162) state that beneficence refers to *doing good* and not harming the respondents. The researcher protected the respondents from emotional harm by explaining the information contained in the data collection instrument (Annexure A) and information contained in the informed consent (Annexure D) to enhance the understanding of the respondents regarding the research study. The respondents were further requested not to write their names and the names of the institutions on the questionnaire. The respondents were allowed to choose whether to participate in the study or not.

Protection from harm is often referred to as principle of *non-maleficence* (Moule & Goodman 2014:60). This principle means that it is the duty of the researcher to ensure that the respondents are protected physically, psychologically and emotionally. When conducting research with humans, harm and discomfort include physical injury by using invasive methods, or fatigue. Emotional harm includes stress and fear, and social harm includes loss of social support if respondents experience fear or distress (Polit & Beck 2012:152). In this study the researcher explained the purpose of the study and allowed the respondents to express their views and to ask questions related to the study in order to allay anxiety of the respondents (LoBiondo-Wood & Haber 2010:253). The respondents were given the opportunity to withdraw from the study if they wanted to, as stated in the informed consent form (Annexure D). The researcher assured respondents that the information provided to the researcher would be kept confidential to prevent unauthorised people from accessing the data. This was achieved by requesting the respondents not to indicate their names on the questionnaire.

- **The principle of justice**

The principle of justice means that the researcher should be *fair in the treatment of the respondents* and avoid discrimination and exploitation of respondents (Mellish et al 2010:142). This principle indicates that the researcher should be fair to the respondents by not giving preferential treatment to some of the respondents and deprive others thereof. The respondents have the right to *fair selection and treatment*, meaning that the researcher must select the study population in general with fairness and ensure that respondents are treated with dignity and respect (Parahoo 2014:102). In this study the respondents were treated fairly, with dignity and were not discriminated against. All the respondents were given an equal chance to participate in the study.

The researcher must also respect the respondents' *right to privacy* (Brink et al 2012:37). According to LoBiondo-Wood and Haber (2010:252) the right to privacy refers to the freedom an individual has in choosing the time, extent, and circumstances under which information obtained by the researcher may be shared or withheld from others. The researcher should ensure that data collected from the respondents is kept in the strict confidence (Polit & Beck 2012:156). In this study the respondents' right to privacy was included in (Annexure A) the covering letter. The respondents were promised that all their private information or opinions provided to the researcher will not be shared with others and that it will serve no purpose other than to gain information on the study (Brink et al 2012:37). The respondents were not required to give or sign their names anywhere in the questionnaire.

Confidentiality relates to the way the information gained from respondents is treated and assurance is given to the respondents that their information will not be revealed or given to any person outside the research team (Moule & Goodman 2014:455). Names of hospitals will not be used; instead, alphabetical numbering will be used to ensure confidentiality and anonymity of respondents.

Anonymity means that respondents will remain anonymous throughout the research even to the researchers themselves (Fox & Bayat 2007:148). Anonymity also means that the researcher should protect the respondents' rights so that no person, not even the researcher, could link the respondents with the information given (LoBiondo-Wood & Haber 2010:574). In this study the researcher ensured the respondents' anonymity by

not requiring their names on the questionnaire. The information provided by the respondents was not shared with unauthorised persons and the information was not publicly divulged (LoBiondo-Wood & Haber 2010:2).

3.13 CONCLUSION

This chapter dealt with the research methodology. The chosen design for this study is a quantitative approach with an exploratory and descriptive design. This chapter included the following: purpose and objectives of the study, research design and methodology, validity of the research design, the population, sampling, data collection, validity and reliability of the data collection instrument, pre-testing of the instrument, the data collection process, data management, data analysis, acquiring permission and ethical principles.

CHAPTER 4

RESEARCH RESULTS

4.1 INTRODUCTION

This chapter discusses the data analysis, interpretation and findings. Researchers can use quantitative analysis to interpret raw data and quantity the value of variables by counting and measuring them in order to provide answers to research objectives and draw conclusions from the data (Houser 2008:430).

The research results of phase 1 of the study are organised according to the sections of the structured questionnaire. Discussion will take place under the following sections:

- Biographical information
- Empowerment
- Kanter's *Theory of Structural Empowerment*
- Structural empowerment
- Psychological empowerment
- Positive work behaviours and attitudes
- Comparing individual dimensions

4.2 PURPOSE OF THE STUDY

The purpose of the study was to determine what empowerment encompasses, and to establish the reasons for the perceived lack of empowerment of registered nurses. In contributing to the scientific body of knowledge, the final objective was to develop empowerment guidelines which managers can apply in order to enhance the empowerment of registered nurses in their service.

4.2.1 Objectives of the study

The objectives of the study were to

- describe what empowerment entails and its effect on professional conduct in the workplace
- explore the level of empowerment among nurse managers and registered nurses
- ascertain the effect of powerlessness on the professional conduct and behaviour of nurse managers and registered nurses
- establish the reasons for lack of empowerment among nurse managers and registered nurses
- determine if there is a difference in the way in which nurse managers and registered nurses perceive the existing empowerment in the public hospitals
- develop empowerment guidelines for nurse managers and registered nurses

4.3 RESPONSE RATE

A response rate is the rate of participation in a study, calculated by dividing the number of persons participating by the number of person sampled (Polit & Beck 2010:567). The descriptive information of the respondents' response rate per hospital and the contribution of each participating hospital to the respondent population are indicated in table 4.1.

Table 4.1 Response rate and contribution per hospital

Response rate by hospital			Response rate	Contribution of participating hospital to the respondent population (n=267)
Hospital	Questionnaires			
	Distributed	Received		
A	78	42	53.8%	15.7%
B	112	30	26.8%	11.2%
C	222	52	23.4%	19.5%
D	37	24	64.9%	9.0%
E	98	23	23.5%	8.6%
F	189	64	33.9%	24.0%
G	82	16	19.5%	6.0%
H	66	16	24.2%	6.0%
Total	**884**	**267**	**30.2%**	**100.0%**

All nurse managers and registered nurses working in these hospitals were invited to participate in the study. Hospital A contributed 15.7%, Hospital B 11.2%, Hospital C

19.5%, Hospital D 9%, Hospital E 8.6%, Hospital F 24.0%, hospitals G and H both 6% to the total response rate of 30%

The total number of respondents amounted to 267. When planning this study, the researcher wanted to give as many of the nurse managers and registered nurses, working in the selected hospitals, the opportunity to provide their views on how empowered they felt − therefore the reason for doing a census (using the total population). The total population consisted of 155 nurse managers and 729 registered nurses, thus amounting to a total of 884 (refer to Table 3.2). The response rate for this study was therefore only 30.2% which defeated the aim of doing a census. Despite numerous attempts by the researcher to encourage the return of completed questionnaires, the response rate did not increase. The researcher should provide information about response rates, and possible non-response bias. Other respondents may refuse to participate; the refusal to participate can lead to a biased sample. It is important for the researcher to analyse responses with caution where there is an indication of non-response bias (Polit & Beck 2008:359).

The researcher extended the return by two months in order to give more time to the respondents who had not submitted their questionnaires. By doing so, the researcher hoped that the return rate would increase. The researcher asked the nurse ward/unit managers telephonically to remind the respondents to return the completed questionnaires at their earliest convenience. Despite these efforts, the response rate did not increase. In addition the researcher also visited one of the selected hospitals personally to request the respondents to complete the questionnaires. Only 267 questionnaires were returned two months after they had been distributed at the hospitals. The low response rate could be attributed to the fact that the respondents had to complete the questionnaires during their spare time. A higher return rate might have occurred if the respondents had completed the questionnaires during work time or in a group under the supervision of the researcher (Kumar 2011:149).

4.4 DATA ANALYSIS

Polit and Beck (2008:751) state that data analysis is the systematic organisation and synthesis of research data. Basavanthappa (2007:442) indicates that the term analysis refers to the computation of certain measures, along with a search for patterns of

relationship that exist among data groups. Grove et al (2013:46) state that data analysis refers to reducing, organising, and giving meaning to the data; it includes the use of descriptive analysis techniques in order to describe demographic variables and study variables and statistical techniques to test proposed relationships among variables, make predictions, and to examine group differences.

4.4.1 Statistical tests

In this study the following methods and tests were used to analyse the collected data: descriptive statistics, inferential statistics, Cronbach's alpha values (discussed in chapter 3), and analysis of variance (NOVA).

- ***Descriptive statistics*** were used to describe and interpret the respondents' views on empowerment. The term 'descriptive statistics' refers to the statistical techniques and methods designed to reduce sets of data and make interpretation easier (Fox & Bayat 2007:111). Descriptive statistics include measures of central tendency, such as mean, median, and mode; measures of variability, such as range and standard deviation (SD); and some correlation techniques such as scatter plots (LoBiondo-Wood & Haber 2010:310).

  Descriptive statistics are usually presented as frequencies and percentages in the form of tables and graphs (Brink et al 2012:179). The respondents' responses in terms of the dimensions of Kanter's *Theory of Structural Empowerment*, as well as on empowerment as a concept, and organisational structure, were presented as descriptive data in tables and or graphs.

- ***Inferential statistics*** are used to analyse the data collected and to answer the research questions. This is a precise way of discussing how confident a researcher can be when inferring from the results in a sample of respondents drawn from the population (Fox & Bayat 2007:125). According to LoBiondo-Wood and Haber (2010:310), inferential statistics are used to analyse the data collected from the respondents, it also allows the researcher to estimate how reliably the researcher can make predictions and generalise findings based on the data. These authors further point out that with inferential statistics, the researcher tries to draw conclusions that extend beyond the immediate data of the study. In this

study the researcher will not be able to generalise the results of the study to other hospitals that did not participate in the study.

- ***The analysis of variance*** (ANOVA) refers to a statistical procedure for testing mean differences among three or more groups by comparing variability between groups (Polit & Beck 2008:747). In this study, a one-way ANOVA was conducted. Only one independent variable was used to assess the differences between the tenure mean scores on empowerment between nurse managers and registered nurses. Should a difference between means of groups be found, then the F-ratio can be used to determine whether the difference is significant by producing a probability value (p-value). The p-value indicates the statistical significance of a result at a certain level of confidence. For instance if the calculated p-value is smaller than 0.05 it means one can be 95% confident that the results are due to a real relationship between the variables, and not to chance factors (Fox & Bayat 2007:126).

  It is important for the researcher to analyse the non-response of the entire questionnaire in order to assess non-response bias. Non-response bias refers to the differences between participants and those who decline to participate (Polit & Beck 2008:359). Non-response could occur due to the following reasons, refusal to respond, refusal to answer individual or all questions, inability to locate the respondents and not being able to make contact with the respondents (Fox & Bayat 2007:62). The researcher should take into consideration the extent to which the data is representative of the population and interpret the results with caution in order to address non-response bias.

- ***A Pearson's correlation*** was conducted to determine whether there was a relationship between empowerment and the different constructs contained in the data collection instrument. The Pearson test refers to a correlation coefficient that designates the magnitude of the relationship between two variables measured on an interval scale (Polit & Beck 2008:761). LoBiondo-Wood and Haber (2010:326), explain that when researchers wish to explore the relationship between two or more variables, or the degree of association between two or more variables, they seek to determine the correlation between these variables.

The test used for establishing this correlation is called the Pearson's correlation coefficient, expressed as Pearson's r.

Correlation coefficients can range in value from -1 to + 1 but can also be zero, in which case there is no relationship between the variables. A perfect positive correlation is indicated by a +1.0 coefficient and a perfect negative correlation by a -1 coefficient. Once the Pearson's r is calculated, the researcher needs to consult the distribution of this test to determine whether the value obtained is likely to have occurred by chance (LoBiondo-Wood & Haber 2010:327).

4.4.2 Approach to data analysis

Two groups of respondents namely nurse managers and registered nurses participated in the study. The results of the two groups of respondents are combined in the discussion of the descriptive statistics. During the explanation of the inferential statistics, the views of nurse managers and registered nurses are separated.

Data was collected by means of a questionnaire requiring the respondents to indicate their level of agreement to the statements posed by using the following scale. The degree of agreement or disagreement is given a numerical value. According to the scale that ranged from 1 to 5, 1 = strongly disagree (SD), 2 = disagree (D), 3 = neutral (N), 4 = agree (A), and 5 = strongly agree (SA). The response alternatives were adapted from five to three to simply the discussion by grouping together two positive alternatives (strongly agree and agree) and two negative response alternatives (strongly disagree and disagree) into agree and disagree respectively.

Before discussing the results, it must be noted that the neutral responses, specifically related to Kanter's dimensions, are high, varying between 6.5% and 29.6% for some items. This leads to the question whether the respondents understood the question, really did not know or were reluctant to give a positive or negative response thus following the safe neutral route.

The views of the respondents were calculated by means of frequencies and percentages, the latter being rounded to one decimal point. Not all the questions were

answered by all respondents, therefore the total number of respondents for the different questions does not always add up to 267.

4.5 BIOGRAPHICAL PROFILE

This section deals with the biographical profile of the respondents, including their age, gender, and the positions they occupy in the hospital in which they are employed.

4.5.1 Item A1: The positions held by respondents within the hospital

Table 4.2 indicates the positions respondents hold at the hospital where they are employed. Forty-four (17.5%) of the respondents are in nurse manager positions and 207 (82.5%) are in registered nurse positions. Sixteen respondents did not respond to this question. In all organisations the number of managers is usually much smaller than the number of subordinates. In this case there were almost five (4.7) times more registered nurses who participated in the study than nurse managers. Put differently, it could be surmised that each manager was in charge of approximately 5 registered nurses.

Table 4.2 Distribution of respondents per position (n=251)

Position	% of total	n
Nurse managers	17.5%	44
Registered nurses	82.5%	207
Total	**100.0%**	**251**

4.5.2 Item A2: Respondents' tenure in current position

Respondents were requested to indicate how long they had been occupying their current positions at the hospital where they were currently employed. Only 251 respondents responded to this question. Sixteen of the respondents did not indicate the position they occupied in their hospitals.

Table 4.3 provides the tenure periods of respondents in their current position.

Table 4.3 Respondents' tenure period in current position (n=255)

Years in position	% of total	n
1-5 years	24.3%	62
6-10 years	26.7%	68
11-15 years	18.0%	46
16-20 years	12.2%	31
21+	18.8%	48
Total	**100.0%**	**255**

From the information provided in Table 4.3 it is evident that 193 (75.7%) respondents have been serving in their current positions for six years or longer. This implies that they know their work environments and colleagues well and should be familiar with the policies, procedures, means of acquiring information, support and resources and be acquainted with the power structures in their hospitals and also be aware of what opportunities are available for development and training. It can be expected that some of the 62 (24.3%) respondents who have been employed for five years or less in their current positions, may be newly trained registered nurses, but it may also be due to the fact that some of these respondents might have been promoted to senior and managerial positions within the past five years, giving the impression that they have a short tenure in their current positions. All the respondents who participated in the study were registered nurses of which some were in managerial positions, but all had at least one year's experience or more in their current positions. Twelve respondents did not answer the question about the tenure period in current positions they occupied in their hospitals.

4.5.3 Item A3: Respondents' gender

This section is concerned with the gender of the respondents. The gender distribution of all the respondents who responded to this question is reflected in Table 4.4. The number of female nurses (n=238; 92.2%) is considerably higher than the number of male nurses. Only 20 (7.5%) of the respondents were male nurses; it is however, a common fact that the number of men who are nurses is very small in comparison to the number of women who are nurses (Mellish et al 2010:37). Nine respondents did not answer the question about their gender.

The total number of registered nurses in South Africa in 2016 January (the provincial distribution of nursing manpower versus the population of South Africa) is 136854, of which 124399 are female nurses and 12455 are male nurses. In the Mpumalanga Province the total number of registered nurses is 7106, and of this number 6345 are female registered nurses and 761 are male registered nurses. These figures indicate that in South Africa nursing is predominantly a female profession. The low number of male respondents in this current study is also supported by the statistics obtained from the South African Nursing Council with regard to the provincial distribution of nursing manpower versus the population of South Africa (www.sanc.co.za/stats.htm). Neither the South African Nursing Council nor (according to information obtained from the Mpumalanga Department of Health) the Mpumalanga Provincial office keeps statistics of the gender of registered nurses occupying specific positions in the respective institutions.

Table 4.4 Gender distribution of the respondents (n=258)

Gender	% of total	n
Male	7.8%	20
Female	92.2%	238
Total	**100.0%**	**258**

4.5.4 Item A4: Respondents' age

It was important to ascertain the age of respondents as indicated in Table 4.5. Two-hundred and fifty seven respondents answered the question. Thus ten respondents did not answer the question on the respondent's age. The majority of respondents (n=227; 88.3%) were aged between 36 and 56+ years. Nurses younger than 35 were in the minority (n=30: 11.7%). The respondents were requested to indicate their age in order to assess whether there is a relationship between age and empowerment.

Table 4.5 Age distribution of the respondents (n=257)

Age	% of total	n
21-25 years	1.2%	3
26-30 years	3.5%	9
31-35 years	7.0%	18
36-40 years	15.6%	40
41-45 years	21.0%	54
46-50 years	21.7%	56
51-55 years	16.0%	41
56+ years	14.0%	36
Total	**100.0%**	**257**

4.6 DIMENSIONS PERTAINING TO KANTER'S THEORY OF STRUCTURAL EMPOWERMENT

Having dealt with a few biographic aspects, the following section focuses on the data derived from items and variables related to the objectives of the study.

The discussion will first focus on empowerment as a concept which does not specifically form part of Kanter's three components or 14 dimensions but the researcher was of the opinion that the respondents' knowledge of this concept should be tested. Thereafter data pertaining to the dimensions of Kanter's *Theory of Structural Empowerment* will be discussed under the headings of *structural empowerment*, *psychological empowerment*, and *positive work behaviours and attitudes* (refer to Table 2.1), and lastly organisational structure. Organisational structure as a concept was included in this study because it deals with organisational structures that enable employees and managers to meet the goals and objectives of the organisation and also impacts on the empowerment of staff (Roussel 2013:225).

4.6.1 Item 5: Empowerment

Empowerment refers to the process of enabling workers to set their own work goals, make decisions, and solve problems within their sphere of responsibility (Moorhead & Griffin 2010:125). If nurses are allowed to give input in decisions, to have control over their work environments and to receive feedback about actions taken or not taken, and to have control over their practice and their lives, a feeling of being empowered is

cultivated (Yoder-Wise 2007:37). Therefore the statements posed in this section sought to determine the respondents' involvement in empowering activities in the work environment.

Table 4.6 Views of the respondents on empowerment activities at their workplace (n=263)

Items		Disagree		Neutral		Agree		Total	
		n	% of total	n	% of total	n	% of total	n	% of total
5.1	I participate in policy formulation.	109	42.6%	36	14.1%	111	43.4%	256	100.0%
5.2	I am encouraged to make decisions that affect my unit.	46	18.3%	36	14.3%	169	67.3%	251	100.0%
5.3	My supervisor practices participative management when making decisions.	37	14.6%	37	14.6%	179	70.8%	253	100.0%
5.4	I am permitted to learn from making mistakes.	34	14.3%	31	13.1%	172	72.6%	237	100.0%
5.5	I am allowed to apply all my competencies and skills in problem-solving actions in my work environment.	22	8.4%	26	9.9%	215	81.7%	263	100.0%

The information contained in Table 4.6 portrays the respondents' views about their involvement in managing their units and work environments. Two hundred and fifteen respondents (81.7%) were permitted to apply their problem-solving skills, 172 (72.6%) could learn from their mistakes, 179 (70.8%) were involved in participative management activities, and 169 (67.3%) were encouraged to make decisions about their units, whereas 46 (18.3%) respondents indicated they were not encouraged to make decisions that affect their units. Almost an equal number of respondents agreed (n=111; 43.4%), and 109 (42.6%) disagreed that they were involved in policy formulation. An explanation for the latter could possibly be that policy formulation usually takes place at higher levels within an institution and most (n=207; 82.5%) of the respondents were not in managerial positions but were functioning as registered nurses working under the supervision of nurse managers.

It is evident that respondents were permitted to use their competence in the management of their units, thus allowing them freedom to grow and learn from their mistakes. Based on the empowerment activities at the workplace the results indicate that the respondents reported mostly positive views about empowerment activities noted.

The results in Table 4.6 show that some of the respondents felt that they were not involved in policy formulation, therefore there is a need to create opportunities for nurse managers and for registered nurses to participate in policy development processes to allow nurses to gain experiential knowledge, exposure and confidence in the area of health policy development (Shariff & Potgieter 2012:5). These results are in line with Kanter's theory which indicates that managers should provide conditions that will promote work effectiveness, such as the creation of opportunities for employees' development (Orgmbidez-Ramos et al 2014:29).

The results also reveal that supervisors permitted participative management (n=179; 70.8%) which allowed the respondents to participate in decision-making related to their units (n=69; 67.3%). The findings of the study conducted by Manojlovich and Laschinger (2007:262) on the nursing work model support the involvement of nurses in decision-making by promoting the participation of nurses in hospital affairs, collaborative nurse/physician relations, and by advocating for nurses to be part of all hospital committees in order to enhance the quality of work life for nurses.

However, information collected from 109 respondents in an open-ended question dealing with the challenges/problems they experienced regarding their decision-making role in their organisations, 64 (58.7%) of the respondents felt that they were not involved in decision-making, 27 (24.8%), 9 (8.3%) indicated that decision-making was 'unfair and judgemental.' Nine (8.3%) indicated that seniors used the telling style of leadership rather than allowing subordinates to exercise autonomy to control activities in the workplace.

In contrast, information collected from 81 respondents responding to the open-ended question on the kind of assistance they provided to their supervisors in making job-related decisions 35 (43.2%) indicated that they assisted their supervisors by giving inputs on topics that could be discussed in meetings, 19 (23.5%) assisted by

participating in strategic planning, 13 (16.0%) identified unit challenges and assisted their supervisors in finding solutions to solve the identified challenges, 14 (17.3%) felt that they were not allowed to assist their supervisors with decision-making. The information reported by the respondents who indicated that they provided assistance to their supervisor shows that they were involved in participative management by giving inputs on topics that could be discussed in meetings. As a result they felt empowered, believing that they contributed to the achievement of the organisation's goals and to the success of the organisation by giving their inputs.

The involvement of the respondents in policy formulation and decision-making as well as in participative management is in line with the dimension of "opportunity" in Kanter's *Theory of Structural Empowerment.* These results indicate that nurse managers created work environments that facilitated the empowerment of registered nurses, although not all of the respondents felt that the work environments were empowering. The lack of involvement in decision-making is not in line with Kanter's Theory which suggests that access to structural empowerment such as involvement in decision-making will strengthen nurses' perception of empowerment (Manojlovich 2007:12).

4.7 DIMENSIONS PERTAINING TO KANTER'S THEORY OF STRUCTURAL EMPOWERMENT

The next section focuses on the three components of Kanter's *Theory of Structural Empowerment*, namely *structural empowerment*, *psychological empowerment* and *positive work behaviours and attitudes*. The three components contain 14 dimensions which are discussed in the following section.

4.7.1 Structural empowerment

The component of structural empowerment is divided into six dimensions, which are: opportunity, information, support, resources, formal power and informal power.

4.7.1.1 Item 6.1: Opportunity dimension

According to Knol and Van Linge (2009:360), opportunity refers to self-determination, growth, a feeling of challenge and the opportunity to learn and grow. Laschinger et al

(2009:229) state that access to opportunities for learning, growth, and advancement in the organisation results in greater employee satisfaction, commitment and productivity.

Table 4.7 Views of the respondents on opportunities they receive from the workplace (n=263)

Items		Disagree		Neutral		Agree		Total	
		n	% of total	n	% of total	n	% of total	n	% of total
6.1.1	My supervisor allows me to attend job-related seminars to improve my skills.	38	14.5%	30	11.5%	194	74.0%	262	100.0%
6.1.2	My supervisor coaches me when I am uncertain about a certain task or function.	29	11.1%	27	10.3%	205	78.5%	261	100.0%
6.1.3	My supervisor delegates challenging tasks to me.	26	10.2%	26	10.2%	202	79.5%	254	100.0%
6.1.4	My supervisor considers my requests when compiling the off- duty roster.	16	6.1%	17	6.5%	230	87.5%	263	100.0%
6.1.5	My supervisor gives me the opportunity to participate in management decisions in the area of my responsibilities.	33	12.8%	27	10.5%	198	76.7%	258	100.0%

The greater majority of respondents (n=194; 74.0% and above) reacted positively to the five statements posed in relation to receiving opportunities for growth and development. Table 4.7 shows that 230 (87.5%) respondents noted that their off-duty requests were considered by the supervisor when compiling the off-duties roster, but 16 (6.1%) respondents disagreed in this regard. Two hundred and two (79.5%) were delegated challenging tasks, and 205 (78.5%) were coached by their supervisors when they were uncertain about certain tasks or functions. One hundred and ninety-eight (76.7%) respondents were given the opportunity to participate in management decisions in the area of their responsibilities; however, 33 (12.8%) disagreed about being given opportunities to participate in management decisions in the area of their responsibilities. One hundred and ninety-four (74.0%) respondents were allowed to attend job-related seminars to improve their skills, whereas 38 (14.5%) felt that they did not receive that privilege.

The cited results are supported by the information obtained from 176 of the responses to the relevant open-ended question “What kind of assistance do you receive from your

supervisor regarding delegated tasks?" Sixty-nine (39.2%) of the respondents felt that they received assistance from their supervisors regarding delegated tasks, through in-service training, orientation and mentoring until they were able to perform the tasks well, 9 (5.1%) respondents indicated that "my supervisor checks the task that I have done and gives remarks of appreciation and further advice on ways to performing the task", 39 (22.2%) felt that tasks were delegated according to their scope of practice, and 17 (9.7%) indicated that their supervisors provided them with more staff when there was a shortage in their unit. Whereas, 42 (23.9%) respondents indicated that they did not receive any assistance, no matter how challenging the tasks were.

In support of Kanter's Theory, making sure that all registered nurses receive the opportunity to attend workshops and seminars as a means of developing would contribute to empowering the 14.5% (n=38) respondents who felt deprived of this opportunity. Ivancevich et al (2014:114) proposed that nurse managers should create an empowering environment for all nurses, in order to allow nurses to learn new skills to enhance their self-confidence. The creation of an opportunity for the respondents to grow, allowed respondents to utilise their personal skills and their abilities during the provision of care to patients (Orgambidez-Ramos et al 2014:34).

4.7.1.2 Item 6.2: Information dimension

Information refers to knowledge gained from the analysis of data collected (Motacki & Burke 2011:147). Disseminating information at the various points of service delivery is carried out for communication, decision-making and the negotiation purposes (Muller et al 2011:17). The sharing of information via supervision and consultation enables the organisation to maintain openness and a sense of a commonly held organisational focus (Hardina, Middleton, Montana & Simpson 2007:62). A lack of information prevents nurses from rendering quality patient care and limits the empowerment of nurses (Kelly 2008:144).

Table 4.8 Views of the respondents on information they receive at the workplace (n=263)

Items		Disagree		Neutral		Agree		Total	
		n	%	n	%	n	%	n	%
6.2.1	My supervisor allows me to give input on issues that relate to my tasks/responsibilities.	17	6.5%	21	8.1%	222	85.4%	260	100.00%
6.2.2	My supervisor shares his/her experience and expertise with me.	39	15.4%	31	12.2%	184	72.4%	254	100.0%
6.2.3	My job description is relevant to the job I am expected to perform.	32	12.4%	20	7.7%	207	79.9%	259	100.0%
6.2.4	I am oriented with regard to new policies and organisational procedures.	22	8.4%	35	13.4%	205	78.2%	262	100.0%
6.2.5	My supervisor regularly gives me feedback regarding my work.	30	11.5%	37	14.2%	194	74.3%	261	100.0%
6.2.6	My supervisor provides me with information that I need to carry out my duties.	18	6.8%	29	11.0%	216	82.1%	263	100.0%

The results in Table 4.8 provide evidence that the greater majority (n=184; 72.4%) of respondents had a positive experience with regard to the sharing of information in different forms. Of the respondents, 222 (85.4%) were permitted to give inputs on issues that were related to their responsibilities, 216 (82.1%) were provided with information that they needed during the execution of their nursing duties, 207 (79.9%) were provided with relevant job descriptions, which assisted them to carry out their responsibilities, while 194 (74.3%) reported that their supervisors gave them regular feedback regarding their work. The results show that there was good communication in terms of the seniors of these respondents providing the necessary information, guidance and feedback. It could be deduced that the respondents were molded and socialised to become independent practitioners as their supervisors shared their experiences and expertise with them. Two hundred and five (78.2%) agreed that they were oriented with regard to new policies and organisational procedures, while 39 (15.4%) disagreed that their supervisors shared their experience with them.

However, in contrast to the above results, 60 respondents responding to the open-ended question, enquiring about the most important barriers to their performance mostly gave a negative picture of their experiences as they lacked information because of the barriers that existed in their organisations. Six (10.0%) stated that they were rotated too often thus they were unable to acquire new information, 12 (20.0%) stated that there was ‘poor communication between staff, ‘and a ‘lack of computers and e-mail facilities for writing reports,’ 4 (6.7%) respondents indicated that they did not experience any barriers to their performance.

The results from closed-ended questions about the views of the respondents on information they received at the workplace suggest that respondents were provided with information. They learned from the information they received and applied the knowledge gained to new situations, such as giving input on issues that relate to their tasks or responsibilities.

Information is a dimension of structural empowerment within Kanter’s Theory and an important aspect within the work environment or any relationship. Information is the means of knowing, learning, growing and understanding. These results obtained from the closed and open-ended questions show that there were mostly empowering, but also a few disempowering aspects relating to the access of necessary information. The latter is not in line with Kanter’s Theory which indicates that the possession of information by employees allows them to make informed decisions, and enables them to pass on the information to other nurses (Gilbert et al 2010:340).

4.7.1.3 Item 6.3: Support dimension

Support refers to receiving feedback and guidance from subordinates, peers and superiors (Laschinger et al 2009:229). Support consists of emotional support and helpful advice or hands-on assistance (Ning et al 2009:2643). Examples within a support system of an organisation could include transport services, clerical support services, and hospitality services (Yoder-Wise 2007:275).

Table 4.9 Views of the respondents on the availability of support from their supervisors (n=262)

Items		Disagree		Neutral		Agree		Total	
		n	% of total	n	% of total	n	% of total	n	% of total
6.3.1	My supervisor allows me to utilise my talents, such as analytical skills, to solve problems in my unit.	29	11.2%	38	14.7%	191	74.0%	258	100.0%
6.3.2	My supervisor listens to my concerns.	26	10.1%	29	11.2%	203	78.7%	258	100.0%
6.3.3	My supervisor considers my suggestions.	24	9.4%	45	17.6%	187	73.0%	256	100.0%
6.3.4	My supervisor gives clear direction when delegating responsibility.	28	10.7%	31	11.8%	203	77.5%	262	100.0%
6.3.5	Recognition is given for work well done.	62	23.8%	43	16.5%	155	59.6%	260	100.0%

Table 4.9 indicates that 203 (77.5%) respondents agreed that their supervisors gave them clear directions when delegating responsibilities. The experience of the respondents are supported by research findings of Skytt et al (2014:6), who highlighted that support was mostly given to employees during delegation when requested. The support offered by the managers to their employees included being present at the workplace to answer questions, giving feedback and allowing themselves to be phoned after office hours.

One hundred and ninety-one respondents (74.0%) were given the opportunity to use their analytical skills to solve their unit's problems, however, 29 (11.2%) respondents disagreed that their supervisors allowed them to use analytical skills to solve problems. One hundred and eighty-seven (73.0%) indicated that their supervisors considered their suggestions in work-related issues. One hundred and fifty-five (59.6%) respondents indicated that recognition was given for work well done, whereas 62 (23.8%) did not receive this recognition. The latter finding where almost a quarter of the respondents did not receive acknowledgement for doing their work well, can have a demoralising effect on employees especially where the criteria for good performance are not self-evident. This might cause managers to manipulate the system and recognise their favourite employees rather than acknowledging the efforts of the rest of the employees. This

could result in less proficient performance by other employees who might wonder whether their efforts are worthwhile and should be sustained (Robbins et al 2010:189).

Of the 122 responses to the open-ended question, enquiring about the kind of assistance they received from their supervisors regarding delegated tasks, 97 (79.5%) respondents indicated that they received support in the form of 'hands-on assistance', and that 'tasks were delegated according to their scope of practice'. Twenty-five (20.5%) indicated that they were given support, without mentioning the type of support they received. The results of this section indicate that the majority of the respondents were of the opinion that their supervisors provided them with support; thus engendering cooperation, growth and the means to be innovative in terms of work-related matters.

They therefore benefitted from the support dimension within the *structural empowerment* component of Kanter's Theory. Newstrom (2015:39) confirms that managers who support their employees in the work environment enhance participation and task involvement in the organisation, and assist employees to solve problems and to accomplish their work.

4.7.1.4 Item 6.4: Resources dimension

According to Jones (2007:104), resources are anything useful in the consumption or production of a product or service, such as nursing care, new equipment, supplies and money. Without adequate resources, even the most empowerment-oriented organisation can lose its focus (Hardina et al 2007:62).

Table 4.10 Views of the respondents on the availability of resources in the workplace (n=265)

Items		Disagree		Neutral		Agree		Total	
		n	% of total	n	% of total	n	% of total	n	% of total
6.4.1	My unit is provided with sufficient supplies on an on-going basis to perform the tasks and patient care activities.	116	43.8%	55	20.8%	94	35.5%	265	100.0%
6.4.2	My employer provides the equipment necessary for me to execute my allocated tasks.	109	41.4%	72	27.4%	82	31.2%	263	100.0%
6.4.3	My supervisor requests my input when compiling the operational budget.	123	46.6%	40	15.2%	101	38.3%	264	100.0%
6.4.4	I am provided with adequate personnel to enable me to meet the organisational goals.	138	52.1%	64	24.2%	63	23.8%	265	100.0%
6.4.5	In my unit, we exceed the allocated time for meetings.	101	38.8%	60	23.1%	99	38.1%	260	100.0%

The responses to the statements posed about resources were predominantly negative in nature, and the high percentage (15.2% to 27.4%) of neutral responses to all five statements, which directly affect every registered nurse, is reason for concern.

The high percentage of neutral in this dimension represented by for instance 60 (23.1%) of the respondents on the question dealing with “In my unit, we exceed the allocated time for meetings” suggests that the respondents might have decided to select the neutral responses because they did not want to indicate their undesirable opinion (Edward & Smith 2014:2).

Table 4.10 shows that 138 (52.1%) of the respondents indicated that they were not provided with adequate personnel to enable them to meet the organisational goals, however, 63 (23.8%) agreed that they were provided with adequate personnel. One hundred and twenty-three (46.6%) felt that their supervisor did not request their input when compiling the operational budget. One hundred and nine (41.4%) felt that they were not provided with the necessary equipment needed to execute their allocated

tasks, and 116 (43.8%) stated that they were not provided on an ongoing basis with sufficient supplies needed for their jobs and for patient care. One hundred and one (38.8%) indicated that the time allocated for meetings was not exceeded in their units, but almost an equal number (n=99; 38.1%) agreed that meetings exceeded the allocated time. It is clear that the dimension of resources, which contributes to *structural empowerment*, seems to be a shortcoming in practice with supplies, equipment and personnel being in short supply.

Of the 184 responses to the open-ended question enquiring about the most important barriers to their performance in the organization, the respondents revealed the following barriers: 78 (42.4%) cited that there was a lack of material resources/equipment, and 106 (57.6%) cited that there was a shortage of nursing staff and doctors.

Further information was gathered from 24 responses to the open-ended question enquiring the respondents to indicate any resources which might enhance the performance of their allocated duties. Six (25.0%) indicated that more competent nurses should be employed, 3 (12.5%) stated that they needed medical equipment, 4 (16.7%) needed computers and training in basic computer skills, 6 (25.0%) felt that they needed in-service training and 5 (20.8%) respondents indicated that allocation of responsibilities should be according to knowledge and skills.

The results of the closed-ended question pertaining to the *structural empowerment* component on the availability of resources in the workplace, indicate that between 41.4% (n=109) and 52.1% (n=138) of the respondents reported a lack of resources in their hospitals. One respondent aged between 31 and 35, indicated that nurses were delegated to perform doctor's duties, for example the collection of blood specimens from patients. Lack of resources is contrary to Kanter's *Theory of Structural Empowerment* which requires that employees be provided with the necessary resources such as money, material, supplies and equipment that they need in order to achieve organisational goals (Gilbert et al 2010:340).

4.7.1.5 Item 6.5: Formal power dimension

Formal power can also be referred to as position power because it deals with formal authority over subordinates. Position power is high when the leader has power to plan

and direct the work of subordinates, to evaluate it, and to reward or punish them (Daft 2011:62). Power depends on the ability to accomplish goals from that position (Yoder-Wise 2007:174). Formal power is associated with jobs that have high visibility, are essential to the organisation and require independent decision-making (Wagner et al 2010:449).

Table 4.11 Views of the respondents on access to formal power in the workplace (n=266)

Items		Disagree		Neutral		Agree		Total	
		n	% of total	n	% of total	n	% of total	n	% of total
6.5.1	I am permitted to make decisions within the scope of my responsibility.	30	11.5%	33	12.6%	199	76.0%	262	100.0%
6.5.2	I am allowed to use my discretion in matters relating to my job.	28	10.9%	49	19.0%	181	70.2%	258	100.0%
6.5.3	Appropriate in-service education programmes are available, allowing me to grow professionally.	41	15.4%	34	12.8%	191	71.8%	266	100.0%
6.5.4	My supervisor recognises my professional developmental needs.	45	17.1%	55	20.9%	163	62.0%	263	100.0%
6.5.5	I am made aware of the hospital's goals and objectives.	42	16.0%	30	11.4%	191	72.6%	263	100.0%

Responses pertaining to the statements contained in Table 4.11 were predominantly positive, ranging between 70.2% and 76.0% in agreement with the statements. The data shows that 199 (76.0%) respondents were allowed to make decisions that were within their scope of responsibilities, 191 (72.6%) were informed about the hospital's goals and objectives, 181 (70.2%) of the respondents were allowed to use their discretion when faced with matters related to their jobs. The use of discretion is supported by Kanter's *Theory of Structural Empowerment,* which indicates that formal power is found in jobs that are visible and central to the purpose of the organisation and that allows for discretion in decision-making (Miller, Goddard & Laschinger 2001:2). It was indicated by 191 (71.8%) that appropriate in-service education programmes were available in their organisations and 163 (62.0%) were allowed to grow professionally.

However, 41 (15.4%) did not agree that in-service education programmes were available. Eight respondents expressed a wish to undergo training for basic computer skills and neonatal care training. This study reveals that most (n=199; 76.0%) of the respondents were given opportunities to exercise formal power in their nursing units which would contribute to a sense of being empowered.

4.7.1.6 Item 6.6: Informal power dimension

Informal power refers to relationships or alliances with sponsors, peers and subordinates (Wagner et al 2010:449). Leaders can develop networks and they can influence others outside of formal meetings to understand the needs of subordinates and their concerns (Daft 2011:338).

Table 4.12 Views of the respondents on means of gaining informal power in the workplace (264)

Items		Disagree		Neutral		Agree		Total	
		n	% of total	n	% of total	n	% of total	n	% of total
6.6.1	My supervisor organises sponsors for seminars that are related to the job.	131	49.6%	57	21.6%	76	28.8%	264	100.0%
6.6.2	My colleagues and I share knowledge to empower one another.	18	6.9%	23	8.8%	221	84.4%	262	100.0%
6.6.3	I am allowed to establish professional networks with other registered nurses, to share ideas about patient care.	41	15.5%	58	22.0%	165	62.5%	264	100.0%
6.6.4	My supervisor respects me for the expertise I exhibit in my work.	35	13.4%	57	21.8%	170	64.9%	262	100.0%
6.6.5	My supervisor considers the contributions of subordinates.	30	11.5%	50	19.2%	181	69.3%	261	100.0%

Apart from the negative responses (49.6%) to the first statement contained in Table 4.12, the remaining four responses were positive ranging between 62.5% and 84.4%. The high level (19.2% to 22.0%) of 'neutral' responses in this section raises the question as to whether the respondents fully understood these statements. Information portrayed in Table 4.12, shows that 221 (84.4%) of the respondents shared knowledge

with colleagues and so empowered one another, 181 (69.3%) agreed that their supervisors considered their contributions, 170 (64.9%) stated that their supervisors respected the expertise that they exhibited in their work. One hundred and sixty-five (62.5%) felt that they were allowed to establish professional networks with other registered nurses and could share ideas about patient care, whereas 41 (15.5%) respondents felt they had limited access to informal power. The majority of the respondents experienced some form of informal power as informal power develops from close contact, and the interaction with other people in and outside the organisation, which is supported by the 221 (84.4%) respondents indicated they shared knowledge with colleagues in order to empower one another**.** This indicates that the respondents felt that it is important to develop effective networks with other health care professionals within the workplace in order to be seen as contributing to the organisational goals.

One hundred and thirty-one (49.6%) respondents disagreed that their supervisors organised sponsors for seminars related to the job. In fact, in most hospitals a designated person or entity is tasked with the responsibility for the training and development of staff. This person would thus acquire sponsors and arrange seminars - not the unit supervisor. This could explain the negative response.

Having dealt with the data of the six dimensions (opportunity, information, support, resources, formal power and informal power) of *structural empowerment* which form the first component of Kanter's Theory, the second component, *psychological empowerment* will now be discussed.

4.7.2 Psychological empowerment

The following section focuses on the four dimensions of *psychological empowerment* which are meaning, confidence, autonomy and impact. However, 'confidence' will be replaced with 'competence' in the discussion as was explained under the under point 2.3.2 in Chapter 2.

4.7.2.1 Item 7.1: Meaning dimension

Meaning reflects the degree to which an individual believes in and cares about work goals and purpose (Rawat 2011:143). Meaning as a dimension also refers to caring about one's work, enjoying it and taking it seriously (Whitehead et al 2007:71).

Empowered nurses feel that their work is important to them and they care about what they are doing (Stander & Rothmann 2010:1). It thus has meaning for them.

Table 4.13 Views of the respondents regarding the meaning of their work (n=264)

Items		Disagree		Neutral		Agree		Total	
		n	% of total	n	% of total	n	% of total	n	% of total
7.1.1	I am allowed to set goals for my ward/unit.	44	16.9%	62	23.8%	154	59.2%	260	100.0%
7.1.2	My supervisor appreciates and supports the goals I establish.	59	22.4%	68	25.9%	136	51.7%	263	100.0%
7.1.3	I am allowed to express my beliefs and values in my unit.	48	18.3%	52	19.8%	163	62.0%	263	100.0%
7.1.4	I regard myself as competent in the manner I execute my duties.	6	2.3%	12	4.5%	246	93.2%	264	100.0%
7.1.5	I am capable of identifying conditions that foster powerlessness.	10	3.9%	37	14.3%	212	81.9%	259	100.0%

Responses in Table 4.13 are positive ranging widely between 51.7% and 93.2%, but the 'neutral' scores are also high (14.3% to 25.9%). The data shows that 246 (93.2%) of all the respondents felt competent in the manner they executed their duties, 212 (81.9%) were of the opinion that they were capable of identifying conditions that foster powerlessness. According to Finkelman and Kenner (2013:495) the conditions that foster powerlessness in employees may include lack of control over unit work activities and not being listened to by supervisors, thus preventing the respondents from contributing positively to their units. One hundred and sixty-three (62.0%) indicated that they were allowed to express their beliefs and values in their units, 136 (51.7%) felt that their supervisors appreciated and supported the goals that they had established, but 59 (22.4%) did not experience this appreciation. One hundred and fifty-four (59.2%) were allowed to set goals for their wards/units. Mullins and Christy (2013:468) are of the opinion that managers should not ignore goals established by their subordinates but rather give credit for good performance and not only criticise and respond negatively when an employee has failed to meet the set standards of performance.

4.7.2.2 Item 7.2: Competence dimension

The replacement of the dimension of 'confidence' in Kanter's Theory with 'competence' Is supported by studies conducted by other researcher on psychological empowerment as was discussed under point 2.3.2.2 in Chapter 2.

According to Wagner et al (2010:449), competence refers to an individual's confidence or belief in his/her abilities to perform activities with proficiency. In addition Kelly (2008:345) states that competence is the ability of the nurse to apply knowledge and interpersonal decision-making, and the psychomotor skills expected for the practice.

Rawat (2011:144) argues that a sense of competence gives employees the belief and confidence that they are able to perform their work roles with skill and success, stimulating them to exert considerable effort on behalf of the organisation. Blanchard (2007:97) states that competence can be gained through formal education, on-the-job training and experience, and that it can be developed over time with appropriate direction and support.

Table 4.14 Views of the respondents on their competence in the workplace (n=266)

Items		Disagree		Neutral		Agree		Total	
		n	% of total	n	% of total	n	% of total	n	% of total
7.2.1	My supervisor considers my capabilities when allocating tasks.	18	6.8%	23	8.6%	225	84.6%	266	100.0%
7.2.2	My supervisor involves me in the planning of my developmental activities after performance appraisal feedback.	61	23.1%	58	22.0%	145	54.9%	264	100.0%
7.2.3	My supervisor acknowledges that I am competent to perform delegated tasks.	23	8.7%	30	11.4%	210	79.8%	263	100.0%
7.2.4	When delegating responsibilities, my supervisor gives me authority to make the necessary decisions.	26	9.8%	31	11.7%	207	78.4%	264	100.0%
7.2.6	I am required to perform tasks that are not covered by my scope of practice.	91	34.2%	34	12.8%	141	53.0%	266	100.0%
7.2.6	I am assertive in speaking out for my own rights in terms of a fair work environment.	36	13.7%	35	13.3%	192	73.0%	263	100.0%

Table 4.14 shows that 225 (84.6%) of the respondents indicated that their supervisors considered their capabilities when allocating tasks, 210 (79.8%) indicated that their supervisors acknowledged that they were competent to perform delegated tasks, 207 (78.4%) reported that their supervisors gave them authority to make the necessary decisions related to the delegated responsibilities, 192 (73.0%) stated that they were assertive in speaking out for their own rights in terms of a fair work environment. One hundred and forty-five (54.9%) indicated that they were involved in the planning of their developmental activities after their performance appraisal feedback. One hundred and forty-one (53.0%) stated that they were required to perform tasks that were not covered by their scope of practice, whereas 91 (34.2%) disagreed that they were made to perform tasks that were not covered by their scope of practice.

The results show that supervisors acknowledged the capabilities of the respondents, and allowed them to function as independent nurse practitioners which gave them the authority to direct the nursing activities of their subordinates. These results are supported by Kanter's Theory which postulates that employees should have the ability to influence their jobs and the workplace (Wagner et al 2010:449).

4.7.2.3 Item 7.3: Autonomy

Hardina et al (2007:235) indicate that autonomy is the extent to which the job permits choice, discretion and independence in completing the work. Yoder-Wise (2007:374) says that autonomy is the freedom to make independent decisions, exceeding the standard nursing practices, which are in the best interests of the patient. Yoder-Wise (2007:374) further states that there are three variables that increase nurse autonomy, namely supportive management, education and experience.

Table 4.15 Views of the respondents on autonomy in the workplace (n=264)

Items		Disagree		Neutral		Agree		Total	
		n	%	n	%	n	%	n	%
7.3.1	My supervisor gives me autonomy to determine the outcomes in my ward/unit.	39	14.8%	77	29.2%	148	56.1%	264	100.0%
7.3.2	My supervisor allows me to control work conduct in my unit.	17	6.4%	42	15.9%	205	77.7%	264	100.0%
7.3.3	Autonomy is actively cultivated among nurses in the organisation.	45	17.8%	75	29.6%	133	52.6%	253	100.0%
7.3.4	My supervisor encourages me to perform at my best.	21	8.0%	31	11.8%	211	80. 2%	263	100.0%
7.3.5	I have discretional power to allocate responsibilities to my subordinates.	24	9.2%	31	11.9%	205	78.8%	260	100.0%

The responses in Table 4.15 are mainly positive ranging between 56.1% and 80.2%. It must be noted that in the case of the first three statements, which elicited the lowest number of positive responses the 'neutral' responses are high (15.9% to 29.6%). The results indicate that 205 (77.7%) of the respondents were allowed to control work conduct in their units. Such work environments that are characterised by high levels of autonomy lead to increased performance, increased decision-making, knowledge and expertise of nurses (Weston 2010:2).

It was indicated by 205 (78.8%) respondents that they were allowed to use their discretion when they allocated duties to subordinates. The results indicated that 148 (56.1%) were allowed the autonomy to determine the outcomes in their wards/units, however, 39 (14.8%) disagreed that they were given the autonomy to determine the outcomes in their wards/units. Two hundred and eleven (80.2%) felt that they were encouraged by their supervisors to perform at their best, however, 21 (8.0%) disagreed that their supervisors encouraged them to perform at their best. Onyishi et al (2012:303) point out that self-determination (autonomy) is reflected by the authority exhibited over the initiation and continuation of work behaviours and processes that allow employees to make decisions about work methods. The fact that autonomy is permitted and

enhanced among the respondents; points to a measure of empowerment of these respondents in accordance with the *psychological empowerment* component of Kanter's Theory.

4.7.2.4 Item 7.4: Impact dimension

According to Stander and Rothmann (2010:3), impact means that employees feel and believe that they are able to make a positive contribution in their organisations in accomplishing unit and organisational goals. Impact also refers to a sense of progression towards a goal and the belief of individuals that their actions contribute towards the vision and mission of the organisation.

Table 4.16 Views of the respondents on the impact they make in the workplace (n=266)

Items		Disagree		Neutral		Agree		Total	
		n	% of total	n	% of total	n	% of total	n	% of total
7.4.1	My supervisor listens to my ideas.	29	10.9%	48	18.1%	188	70.9%	265	100.0%
7.4.2	My supervisor provides me with feedback which enables me to grow.	29	10.9%	33	12.5%	203	76.6%	265	100.0%
7.4.3	My supervisor acknowledges my contribution to my patients' well-being.	30	11.3%	35	13.2%	201	75.6%	266	100.0%
7.4.4	My supervisor recognises my ability to influence job outcomes.	32	12.5%	46	17.9%	179	69.6%	257	100.0%
7.4.5	My supervisor allows me to interact with colleagues to improve nursing practice.	19	7.3%	32	12.2%	211	80.5%	262	100.0%

Table 4.16 indicates that 211 (80.5%) of the respondents stated that they were allowed to interact with their colleagues to improve nursing practice, 203 (76.6%) indicated that their supervisors provided them with feedback, which enabled them to grow. Twenty-nine (10.9%) reported that their supervisors did not listen to their ideas or provide them with feedback which could enable growth, but the ideas of 203 (76.6%) respondents were noted by their supervisors. Two hundred and one (75.6%) noted that their supervisors acknowledged their contribution to their patients' well-being. One hundred

and seventy-nine (69.6%) indicated that their supervisors recognised their abilities to influence their job outcomes; whilst for 32 (12.5%) disagreed that their abilities to influence job outcomes were not recognised.

4.7.3 Positive work behaviours and attitudes

The following discussion is based on the four dimensions of *positive work behaviours and attitudes* as the third component of Kanter's Theory. The four dimensions are job satisfaction, commitment, low stress and low burnout.

4.7.3.1 Item 8.1: Job satisfaction dimension

According to Bagraim et al (2011:74), job satisfaction refers to a person's general attitude towards his or her job. Mullins and Christy (2013:783) state that job satisfaction is an internal state which is reflected through personal feelings of achievement. Whereas Odunlade (2012:1) defines job satisfaction as an individual's reaction to the job experience.

Table 4.17 Views of the respondents on job satisfaction in the workplace (n=265)

Items		Disagree		Neutral		Agree		Total	
		n	% of total	n	% of total	n	% of total	n	% of total
8.1.1	I receive a fair salary for the work that I do.	128	48.3%	40	15.1%	97	36.6%	265	100.0%
8.1.2	The work climate in the ward where I am working is free from harassment.	66	25.2%	45	17.2%	151	57.6%	262	100.0%
8.1.3	My work climate is not challenging.	139	53.1%	40	15.3%	83	31.7%	262	100.0%
8.1.4	My supervisor is approachable.	26	10.1%	26	10.1%	205	79.8%	257	100.0%
8.1.5	I am expected to regularly perform non-nursing tasks.	114	43.3%	46	17.5%	103	39.2%	263	100.0%

The high 'neutral' responses to straightforward questions (items 8.1.1, 8.1.2 and 8.1.5) in Table 4.17 raise questions as to the reason for not responding positively or negatively. The results indicate that 205 (79.8%) respondents felt that their supervisors were approachable, 151 (57.6%) indicated that the work climate in the wards was free

from harassment. However, 66 (25.2%) were of the opinion that their work climate was not free from harassment. One hundred and twenty-eight (48.3%) disagreed that they received a fair salary for the work they did, whereas 97 (36.6%) respondents acknowledged receiving a fair salary. One hundred and fourteen 114 (43.3%) disagreed that they were regularly expected to perform non-nursing tasks, whereas 103 (39.2%) agreed that they were regularly expected to do so.

Measuring job satisfaction is a complex and multi-dimensional notion which can mean different things to different people (Maniram 2009:15), thus the five items contained in Table 4.17 cannot claim to reach a sound answer to the matter as the reliability score of job satisfaction by means of Cronbach's Alpha was only 0.47 that was found to be unreliable. However, based on the five noted items, the respondents found their supervisors approachable. Lumley, Coetzee, Tladiyane and Ferreira (2011:103) state "when supervisors are understanding, friendly, giving praise for good performance, listening to employees' inputs and showing personal interest in the work of employees, they promote job satisfaction among employees". A work environment free of harassment and only having to perform limited non-nursing duties impact positively on how an employee perceives his/her job and it can therefore be deduced that the respondents in this study experienced a fair amount of job satisfaction.

4.7.3.2 Item 8.2: Commitment dimension

According to Ross (2010:69), commitment means the extent to which an individual identifies with, and is involved in an organisation. Ross (2010:70) further states that higher levels of commitment – especially with affective commitment – have been linked positively to outcomes such as attendance, individual performance and organisational citizenship. Lower levels of affective commitment are associated with absenteeism and turnover. Commitment inspires staff to be industrious, outstanding and productive. Under participatory management, commitment is elicited and not imposed (Roussel & Swansburg 2009:200).

Table 4.18 Views of the respondents on commitment in the workplace (n=267)

Items		Disagree		Neutral		Agree		Total	
		n	% of total	n	% of total	n	% of total	n	% of total
8.2.1	My supervisor ensures that relevant in-service training is conducted.	33	12.5%	32	12.1%	200	75.5%	265	100.0%
8.2.2	My supervisor ensures effective utilisation of resources.	26	9.7%	42	15.7%	199	74.5%	267	100.0%
8.2.3	My supervisor is committed to effective patient care.	19	7.1%	41	15.4%	206	77.4%	266	100.0%
8.2.4	My supervisor assists in preparing for promotions.	85	32.4%	58	22.1%	119	45.4%	262	100.0%
8.2.5	My supervisor's leadership style engenders commitment among nurses.	43	16.6%	70	27.0%	146	56.4%	259	100.0%

Table 4.18 illustrates that 206 (77.4%) of the respondents reported that their supervisors were committed to effective patient care and 200 (75.5%) felt that their supervisors ensured that relevant in-service programmes were conducted. The provision of in-service training is supported by Roussel (2013:767) indicating that in-service education programmes should be instituted based on the needs of employees after a thorough assessment in order to be able to provide relevant training for employees.

It was indicated by 146 (56.4%) respondents that their supervisors' leadership styles engendered commitment among nurses, while 43 (16.6%) did not agree with this statement that their supervisors' leadership styles enhanced commitment among nurses. Almost three-quarters (n=199 74.5%) of the respondents indicated that their supervisors attended to the effective utilisation of resources. One hundred and nineteen (45.4%) confirmed that their supervisors assisted them in preparing for promotions. The assistance that the respondents received in preparation for promotions, is in line with Ambad's findings (2012:78), which indicate that employees commit their loyalty to the organisation when they believe they can influence strategic, administrative and operational outcomes at the workplace. However, 85 (32.4%) respondents disagreed with the statement that their supervisors assisted them in preparing for promotions. In this second dimension of *positive work behaviours and attitudes*, the respondents

benefitted from their supervisors' commitment to effective patient care and utilisation of resources, the provision of in-service training, their leadership style and the assistance received by some in preparing for promotions which all contribute to empowerment.

4.7.3.3 Item 8.3: Low stress dimension

According to Jones (2007:364), stress is the nonspecific response of an organism to any pressure or demand. Huber (2010:131) argues that stress is a physical, mental, psychological, or spiritual response to a stressor. A stressor is an experience in a person's environment or relationships that is evaluated by the person as taxing or exceeding the available resources and threatening the sense of well-being. Jones (2007:364) suggests that stress can be resolved through a personal commitment to lifestyle changes, such as getting enough sleep, making contingency plans in case the primary plan does not work, and the use of some interventions planned with professional help (Jones 2007:364). Luthans (2011:298) is of the opinion that organisations should create supportive work environments by ensuring that organisational and individual strategies are implemented in order to lower the stress levels of employees.

Table 4.19 Views of the respondents on low stress in the workplace (n=266)

Items		Disagree		Neutral		Agree		Total	
		n	% of total	n	% of total	n	% of total	n	% of total
8.3.1	I am treated with respect by my seniors.	44	16.7%	46	17.5%	173	65.8%	263	100.0%
8.3.2	The nurses in my ward/unit are overloaded with work.	59	22.3%	26	9.8%	180	67.9%	265	100.0%
8.3.3	My organisation promotes lifelong learning.	49	18.6%	68	25.9%	146	55.5%	263	100.0%
8.3.4	My organisation has a career development plan for every employee.	77	28.9%	54	20.3%	135	50.8%	266	100.0%
8.3.5	Allocation of tasks is according to the individual's abilities.	39	14.7%	40	15.0%	187	70.3%	266	100.0%
8.3.6	My supervisor handles conflict within the ward/unit in a timely and effective manner.	42	15.9%	36	13.6%	186	70.5%	264	100.0%

Even though the responses in Table 4.19 are mainly positive, there are high levels of 'neutral' responses ranging from 13.6% to 25.9%. Table 4.19 indicates that 187 (70.3%) of the respondents were allocated tasks according to their abilities, 186 (70.5%) agreed that their supervisors were able to handle and resolve conflicts timeously and in an effective manner. One hundred and eighty (67.9%) reported that nurses in their units were overloaded with work. Reasons given in open-ended questions were tiredness, difficulty to take tea and lunch breaks, and shortage of staff, but 59 (22.3%) disagreed that nurses were overloaded with work. One hundred and seventy-three (65.8%) felt that they were treated with respect by their seniors. Faulkner and Laschinger's (2008:219) research led to these authors reporting that nurses who experienced respect in their work environments were given opportunities to practice autonomy. Such employees are likely to become satisfied in their work and could be subjected to lower levels of stress because they feel in control. Managers therefore need to create work environments in which employees will feel respected.

One hundred and thirty-five (50.8%) respondents felt that their organisation had a career development plan for every employee, whereas 77 (28.9%) disagreed that this was so.

Based on the respondents' views with regard to work overload, the results suggest that some of the respondents might have experienced high levels of stress, especially employees who found it difficult to cope with stressful situations. Stressful situations could lead to physical tiredness among employees (Yildiz, Ayhan & Erdogmus 2009:114). The results also suggest that most of the respondents experienced low stress levels because they received career development opportunities; also that their abilities were recognised when tasks were delegated and conflicts were handled timeously in an effective manner. These results are supported by Kanter's theory which indicates that when managers give support to employees and allow nurses to participate in decision-making, stress levels are reduced (Patrick & Lavery 2007:5).

4.7.3.4 Item 8.4: Low burnout dimension

Burnout is a general feeling of exhaustion that develops when a person simultaneously experiences too much pressure and has too few sources of satisfaction (Moorhead & Griffin 2010:179). Burnout is a condition where the employee's coping resources have been consumed by work and demands, to the point of poor job performance and

exhaustion. Burnout does not affect everybody; it affects individuals with high expectations to achieve beyond their ability to deliver in the long term (Bagraim et al 2011:242). Burnout is particularly evident in the caring professions.

Table 4.20 Views of the respondents on low burnout in the workplace (n=265)

Items		Disagree		Neutral		Agree		Total	
		n	% of total	n	% of total	n	% of total	n	% of total
8.4.1	My supervisor is judgmental about everything I do.	132	50.8%	67	25.8%	61	23.5%	260	100.0%
8.4.2	I do not have enough time to effectively attend to my patients' needs.	126	47.5%	44	16.6%	95	35.8%	265	100.0%
8.4.3	I am required to work overtime on a regular basis.	126	48.1%	36	13.7%	100	38.2%	262	100.0%
8.4.4	My work environment is noisy.	140	54.9%	46	18.0%	69	27.1%	255	100.0%
8.4.5	I am not given authority to control my job-related tasks and am held accountable.	139	53.3%	59	22.6%	63	24.1%	261	100.0%
8.4.6	The workload and tempo is so high that I never seem to catch up with everything I need to do.	88	34.0%	56	21.6%	115	44.4%	259	100.0%

High levels (13.7% to 25.8%) of 'neutral' responses are evident in this set of results. Table 4.19 shows that 140 (54.9%) respondents disagreed that their work environments were noisy, while 69 (27.1%) noted the contrary. One hundred and thirty-two (50.8%) disagreed that supervisors were judgmental about everything they did, but 61 (23.5%) felt they were judgmental. One-hundred and thirty-nine (53.3%) respondents disagreed that they were not given authority to control job-related tasks, while 63 (24.1%) agreed that they were not given authority to control job-related tasks. One-hundred and twenty-six (48.1%) disagreed that they did not have enough time to attend effectively to their patients' needs, 126 (48.1%) disagreed that they were required to work overtime on a regular basis. However one hundred (38.2%) respondents indicated that they were required to work overtime on a regular basis. Almost half of the respondents disagreed 126 (48.1%) that they were required to work overtime regularly.

Disagreeing with the first five negatively formulated statements in Table 4.20, actually represents a positive response although in this case, the responses varying between

47.5% and 54.9%, are not very high, but they are higher than the 'agree' response. It can thus be deduced that the noted five items do not lead to burnout. The last item relating to workload and tempo (n=115; 44.4%) does however pose a problem and could lead to burnout in the long run. This in addition to having to work overtime on a regular basis (n=100; 38.2%) would probably result in emotional exhaustion as employees were expected to perform at unreasonably high levels (Patrick & Lavery 2007:47). Kanter's Theory suggests that the provision of good and fair work environments lead to higher feelings of empowerment and prevents burnout in employees (Hochwalder 2007:205).

This brings to a close the presentation and discussion on data pertaining to the 14 dimensions of Kanter's Theory under the headings of *structural empowerment*, psychological empowerment and *positive work behaviours and attitudes*.

Organisational structure was identified in the literature as an additional factor which could have an influence on the empowerment of employees. The findings on organisational structure will now follow.

4.8 ITEM 9.1: ORGANISATIONAL STRUCTURE

According to Moorhead and Griffin (2010:407), organisational structure entails a system of tasks, reporting and authority relationships within which the organisation does its work. Muller et al (2011:564) state that an organisational structure is the framework in which the organisation defines how tasks are divided, resources are deployed, and departments are coordinated. Whereas Yoder-Wise (2007:607) indicates that an organisational structure is a framework that divides work within an organisation and delineates points of authority, responsibility, and accountability. It provides a map for communication and outlines decision-making paths (Yoder-Wise 2007:133). Therefore organisational structure was included as a relevant factor affecting empowerment although it does not form part of Kanter's Theory.

Table 4.21 Views of the respondents on the organisational structure of their workplace (n=264)

Items		Disagree		Neutral		Agree		Total	
		n	% of total	n	% of total	n	% of total	n	% of total
9.1	Nurses in my unit are given authority to act according to their post levels.	40	15.2%	39	14.8%	185	70.1%	264	100.0%
9.2	My supervisor adheres to an open door policy.	36	14.1%	49	19.1%	171	66.8%	256	100.0%
9.3	I have more than 15 subordinates reporting to me.	146	55.5%	37	14.1%	80	30.4%	263	100.0%
9.4	I have the authority to institute disciplinary measures against my subordinates.	71	27.2%	37	14.2%	153	58.6%	261	100.0%
9.5	I have the right to initiate a grievance process when aggrieved.	48	18.5%	32	12.3%	180	69.2%	260	100.0%

Table 4.21 shows that 185 (70.1%) of the respondents were given authority to act according to their post levels. These results suggest that the respondents were given the authority to give orders and expect subordinates to obey their orders; and also that the respondents were given the authority to meet their responsibilities (Robbins et al 2010:432). Whereas 40 (15.2%) did not receive the necessary authority, for example to control the daily activities of employees in the nursing unit. One hundred and eighty (69.2%) perceived that they had the right to initiate a grievance process when aggrieved. It must be noted that according to the Labour Relations Act No 55 of 1996, all employees have the right to lodge a grievance should they have good reason.

One hundred and seventy-one (66.8%) agreed that their supervisors adhered to an open-door policy. It is evident that 153 (58.6%) respondents had the authority to institute disciplinary measures against their subordinates, while 71 (27.2%) did not have the same authority. One hundred and forty-six (55.5%) respondents had fewer than 15 subordinates reporting to them, whereas 80 (30.4%) supervised more than 15 subordinates.

In view of the responses on organisational structure, it appears that the majority of the respondents felt empowered. The results indicate that the respondents were given autonomy to act according to their post levels which allowed them to direct the work activities of their subordinates. Supervisors adhered to an open-door policy to allow employees to communicate their concerns with their supervisors (Newstrom 2015:70). The respondents also indicated that they had fewer than 15 subordinates under their span of control. Supervisors with fewer than 15 subordinates under their span of control might be able to coach and to give performance feedback to employees timeously, thus assisting in improving employee performance (Lucas et al 2008:967). These results are in line with Kanter's Theory which supports the creation of a work environment that promotes access to *structural empowerment* (Manojlovich 2007:6).

4.9 ASSESSMENT OF THE DIFFERENCES BETWEEN THE EMPOWERMENT DIMENSIONS

In the following section, attention is given to the meaning and effect of the 14 dimensions of Kanter's *Theory of Structural Empowerment* plus 'empowerment' and 'organisational structure' which do not form part of Kanter's Theory, resulting in16 dimensions by analysing the mean scores of the different dimensions. Kanter's 14 dimensions include *structural empowerment (*which includes the dimensions of opportunity, information, support, resources, formal power, and informal power), and *psychological empowerment* (which encompasses meaning, confidence, autonomy, and impact and *positive work behaviours and attitudes* which relate to the dimension of job satisfaction, commitment, low stress and low burnout). Job satisfaction was left out of the analysis because it was found not to be reliable. This is discussed in section 3.7.2 which deals with validity and reliability of the data collection instrument.

The following tables illustrate the data collected from the two groups of respondents, namely nurse managers and registered nurses.

An empowering category was calculated to show the differences in mean scores between two groups. The differences between the mean scores were calculated for graphical presentation of data and not for the statistical analysis. An empowerment category was calculated in the following manner: All respondents scoring 3.75 or higher on 'empowerment' were categorised as empowered in a dimension of Kanter's theory

pertaining to that specific dimension; and those scoring lower than 3.75 were categorised as not being empowered. The median of empowerment was 3.75 and this figure was used to discriminate between those respondents who were empowered and those who were not.

Table 4.22 contains the mean scores of empowerment, pertaining to the concept of empowerment, the 14 dimensions of Kanter's *Theory of Structural Empowerment* and organisational structure according to the experiences of the total respondent population.

Table 4.22 Mean average scores of each empowerment dimension (n=251)

Dimensions	Std Dev	Mean
Empowerment	0.86	3.59
Opportunity	0.78	3.94
Information	0.75	3.93
Support	0.86	3.77
Resources	0.83	2.75
Formal power	0.79	3.73
Informal power	0.77	3.52
Meaning	0.76	3.78
Competence	0.71	3.75
Autonomy	0.70	3.77
Impact	0.86	3.84
Job satisfaction	No Score	No Score
Commitment	0.86	3.63
Low stress	0.75	3.56
Low burnout	0.78	2.76
Organisational structure	0.80	3.42

The dimension with the highest mean score is opportunity, with a score of 3.94, then information (3.93), followed by support (3.77). This means that the respondents considered opportunity, information and support as the three most important empowering factors within the structural empowerment component according to Kanter's *Theory of Structural Empowerment***.** Employees who have access to opportunities and information feel empowered because they have the necessary information to carry out their duties (Miller et al 2001:3). The resources dimension scored 2.75, the lowest score in this section, indicating that the respondents considered the unavailability of resources the least empowering in the *structural empowerment*

domain. Within the *psychological empowerment* component, the mean scores of the four dimensions (meaning to impact), were very similar-ranging from 3.75 to 3.84, indicating that as meaning, competence, autonomy and impact measured above 3.75, they were considered empowering dimensions as discussed in section 4.10 under the assessment of the differences between the empowerment dimensions.

Within the *positive work behavioural and attitudes* component, job satisfaction was omitted as explained before. Commitment reached a score of 3.63, indicating that commitment was the most empowering dimension. Interpretation of the next two dimensions namely 'low stress' and low 'burnout', requires careful consideration due to the 'low' labeling of these two dimension questions posed to determine the respondents' views about their experience of low stress were mostly formulated as positive statements, thus receiving a mean of 3.56 would be indicative that the respondents agreed with the positive statements, and were therefore not subjected to high stress levels and could the contrary of low stress levels therefore be considered an empowering dimension according to Kanter's Theory through the creation of a supportive work environment (Mullins & Christy 2013:109).

In contrast to the positive statements aimed at measuring stress levels, all of the statements posed for the dimension of low burnout, contained negative factors (such as judgmental attitudes, insufficient time, overtime, noise and no authority), thus agreeing to these statements would illustrate a measure of burnout. However, a mean score of 2.76 was achieved, indicating that the respondents did not agree with the negative statements and it can be deduced that they in fact did not suffer from burnout as measured in this instance. The converse would then be that they experienced low levels of burnout which is in line with Kanter's Theory stating that low burnout was an empowering factor within the *positive work behaviour and attitude* component.

Organisational structure was added as an additional dimension that could impact on the empowerment of employees. Receiving a mean of 3.42 implies that for these respondents, organisational structure was not a strong empowering factor.

4.10 COMPARING INDIVIDUAL DIMENSIONS BY MEANS OF ANALYSIS OF VARIANCE

Analysis of variance (ANOVA) refers to the extension of the t-test, which permits the researcher to compare more than two means simultaneously. The analysis of variance uses variances to calculate a value that reflects the differences between two or more groups (Brink et al 2012:191). This test was used to differentiate between the means of the 16 dimensions in order to discriminate between the dimensions that are considered to be empowering and those that are not empowering.

Table 4.23 Comparing dimensions of the empowerment category

	Empowered category			
	Not empowered < 3.75		Empowered > 3.75	
Dimensions	**Mean**	**Std Dev**	**Mean**	**Std Dev**
Opportunity	3.49	0.76	4.35	0.54
Information	3.54	0.78	4.28	0.52
Support	3.33	0.86	4.17	0.63
Resources	2.40	0.88	2.98	0.92
Formal power	3.38	0.78	4.06	0.66
Informal power	3.43	0.82	4.05	0.62
Meaning	2.99	0.99	3.97	0.83
Competence	3.47	0.93	4.19	0.58
Autonomy	3.38	0.76	4.05	0.57
Impact	3.46	0.91	4.19	0.65
Commitment	3.54	0.97	4.14	0.71
Low stress	3.20	0.81	3.83	0.75
Low burnout	2.90	0.76	2.63	0.78
Organisational structure	3.25	0.77	3.97	0.77

Table 4.23 provides the differentiation between the scores that would label a dimension as being empowering or not. For example, respondents who felt empowered received more opportunities with the result they scored a mean of 4.35, whereas those who were not empowered by 'opportunities' scored 3.49 (thus lower than the 3.75 cut-off point). The respondents, who felt empowered, obtained a mean score of 4.05 to 4.35 for five dimensions within the empowered domain of *structural empowerment*, but obtained a mean score of 2.98 for resources. This score is lower than the other dimensions indicating a lack of resources; however the 2.98 is higher than the 2.40 attributed to

resources by the non-empowered respondents. Therefore empowered respondents presumably have slightly more access to resources than non-empowered respondents.

The results further indicate that the respondents felt empowered pertaining to the four dimensions of *psychological empowerment,* with mean scores ranging between 3.97 and 4.19. The mean scores of the first two dimensions within the *positive work behaviour and attitudes* component, is 3.83 to 4.14 respectively, low burnout, has a mean score of 2.63. Organisational structure has a mean score of 3.97. It can however be deduced that empowered respondents will suffer less from burnout thus substantiating the low score of 2.63.

Table 4.23 further indicates that there were respondents who felt they were not empowered, as the mean score for all the empowering dimensions were below 3.54 for these respondents and ranged between 2.90 to 3.54. It can therefore be deduced that for some respondents the empowering dimensions did in fact empower them in their specific places of work, whereas other respondents were not adequately supported by these dimensions, leading to a sense of not being empowered or even powerlessness, especially if one considers the low score of 2.40 related to resources. It is a well-known fact that public health services are often subjected to a lack of resources in terms of adequately trained staff, well-functioning equipment and supplies as well as medication. The lack of these resources means that patients do not always get the nursing care and treatment that they need (James & Miza 2015:3).

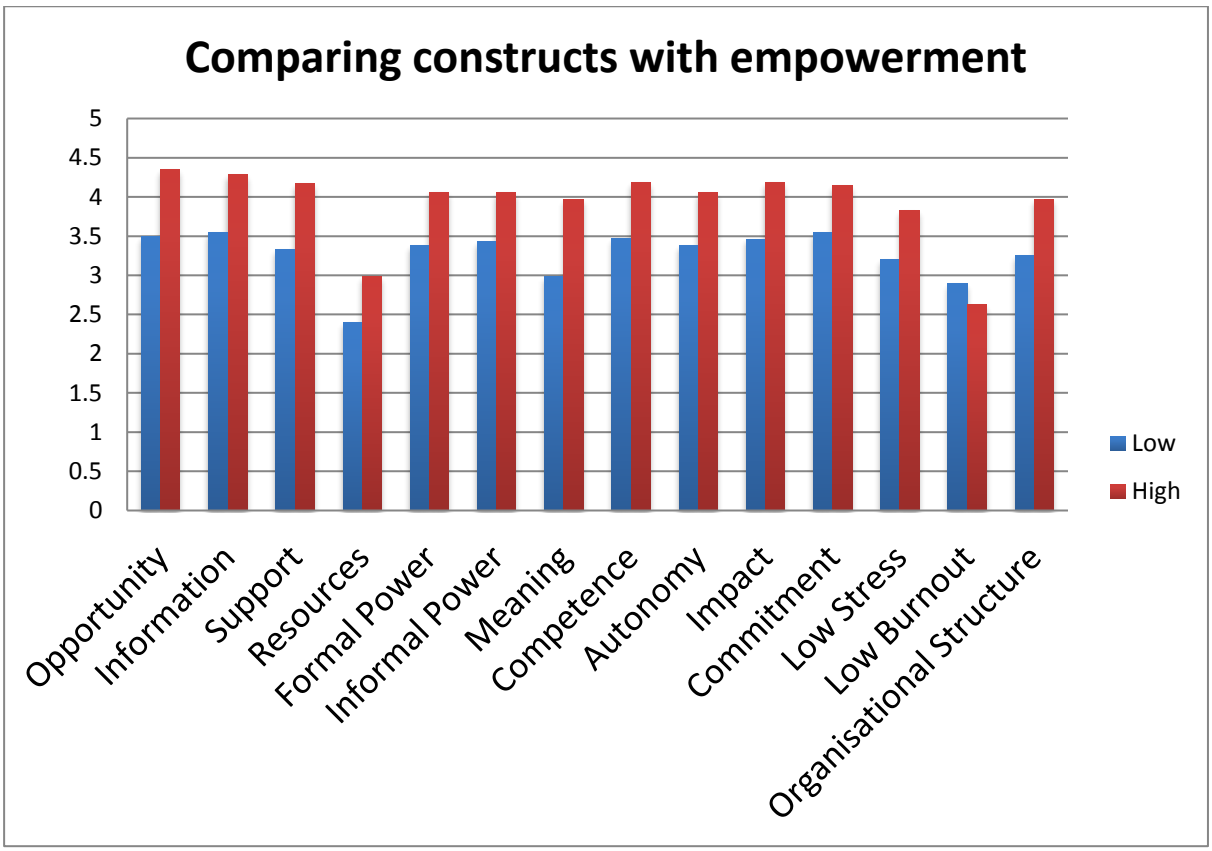

Figure 4.1 **Mean scores of 14 empowerment dimensions (not including job satisfaction) in relation to being empowered or not**

The information in Figure 4.1 is based on the content of Table 4.23. A distinction is made between the respondents who felt empowered by the different dimensions as opposed to those feeling less empowered. Further analysis between the level of perceived empowerment and the years of tenure led to the findings provided in Table 4.24.

Table 4.24 **Comparison of the differences between mean empowerment scores for different years of tenure by means of the Analysis of Variance (ANOVA)**

Level	n=254	Mean	Std Error	Lower 95%	Upper 95%
1-5 years	62	3.3	0.10919	3.1000	3.5301
6-10 years	68	3.7	0.10426	3.4922	3.9029
11-15 years	46	3.5	0.12676	3.2884	3.7877
16-20 years	31	3.6	0.15441	3.3351	3.9434
21+ years	47	3.8	0.12541	3.5583	4.0523

To determine if the difference between the means of different groups are statistically significant, the F-test was performed as part of the ANOVA procedure, which produced a probability value (p-value). The p-value indicates a significant statistical difference at 95% level of confidence, if the calculated p-value is smaller than 0.05 and a significance difference level of 99% if the p-value is 0.01 or less (De Vos et al 2011:274).

A One-way ANOVA was used to determine the differences of empowerment mean scores. This means that only one independent variable ‘tenure’ was calculated in order to determine the real differences between the mean empowerment scores. A significant difference exists between the empowerment scores for the tenure categories. To assess where the specific differences exist a Tukey-Kramer was used in figure 4.2. The means and standard errors on the output indicated in Table 4.24 clearly shows that respondents with 1-5 years of experience has a lower mean score of 3.3 than the other categories indicating that they feel less empowered.

In Table 4.24, the respondents with 1 to 5 years tenure obtained a mean score of 3.3, which is significantly lower at the 95% (p=0.0286) level than that of the mean score of 3.8 for nurses who have been in their positions for 21 years or longer. There was also a significant difference between respondents with 6 to 10 years tenure, with a mean score of 3.7, which was significantly higher at the 95% (p=0.0286) level than the mean score of 3.3 of respondents who had between 1 to 5 years tenure. There was also another significant difference at the 95% (p=0.0286) level between respondents with 16-20 years tenure, with a mean score of 3.6 which is higher than the mean score of respondents who had between 1 to 5 years tenure. It can thus be deduced that the duration of tenure and its concomitant experience and opportunities for growth and development lead to nurses being more empowered.

The information contained in Table 4.24 provides the mean empowerment scores for respondents in relation to their years of tenure. The same data is now presented by means of the Tukey-Kramer analysis, and is illustrated in Figure 4.2

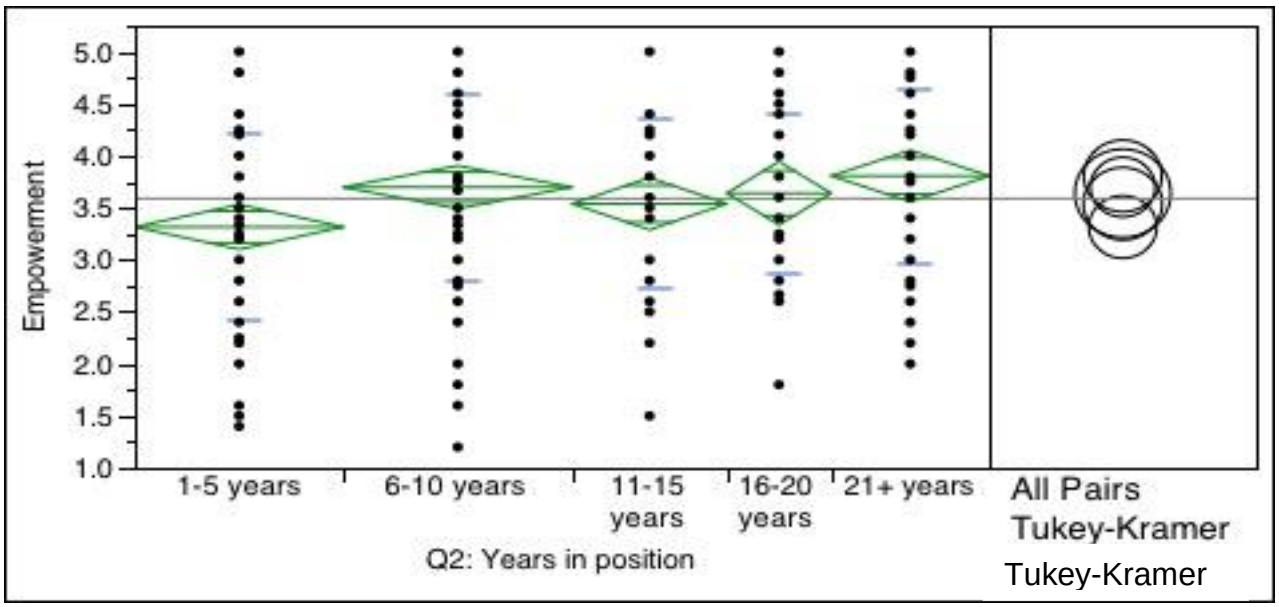

Figure 4.2 Empowerment levels of respondents in comparison with their years of tenure in the same position according to the Tukey-Kramer 0.05 analysis

In consultation with a statistician, the diamond shapes can be explained as follows:

The middle horizontal line in the diamond represents the mean score of destination. The vertical endpoints of the diamond indicate the confidence interval (at 95% or 99%) of the mean. The width of the diamonds indicates the relative sample size. The diamond for the category 1 to 5 years is situated lower on the y axis than the diamonds for the other age intervals substantiating the significant differences that exist between the 1-5 years tenure and age intervals of 6 years and above.

Table 4.25 Indicating differences between the different tenure categories (ANOVA analysis)

Source	DF	Sum of Squares	Mean Square	F-Ratio	Prob > F
Q2: Years in position	4	7.85095	1.96274	2.6554	0.0336*
Error	249	184.04961	0.73916		
C. Total	253	191.90056			

Table 4.25 indicates the p-value of the F-test. This p-value is 0.0336, which is smaller than 0.05, indicating that there was a significant difference between the performance of the different tenure categories at a 95% level of confidence as discussed above. This

indicated that there was a significant difference between the empowerment scores and that of the tenure categories.

Table 4.26 Mean scores of the empowerment dimensions as per respondent group

Items	Nurse managers (n=49)		Registered nurses (n=211)	
	Mean	Std Dev	Mean	Std Dev
Empowerment	4.10	0.77	3.48	0.85
Opportunity	4.10	0.76	3.90	0.79
Information	4.12	0.69	3.88	0.76
Support	3.96	0.97	3.74	0.83
Resources	2.93	0.81	2.61	0.97
Formal power	3.88	0.70	3.70	0.82
Informal power	3.74	0.72	3.75	0.81
Meaning	4.09	0.66	3.37	1.06
Competence	3.91	0.92	3.84	0.83
Autonomy	3.98	0.63	3.68	0.75
Impact	3.88	0.89	3.84	0.85
Commitment	3.91	0.89	3.85	0.89
Low stress	3.61	0.90	3.51	0.84
Low burnout	2.48	0.68	2.79	0.79
Organisational structure	4.04	0.64	3.52	0.87

Table 4.26 provides the mean scores of the 15 empowerment dimensions as experienced by the two groups of respondents. It was evident that the nurse managers considered the empowering dimensions of opportunity, information, meaning and organisational structure as the most important empowering dimensions with mean scores ranging between 4.04 to 4.12. In addition, the empowering dimensions of support, formal power, competence, autonomy, impact and commitment followed closely, with mean scores of 3.88 to 3.98.

The mean scores of the registered nurses for the 15 dimensions were in general lower than those of the nurse managers. Within the *structural domain* the mean empowering scores for opportunity, information, and informal power ranged from 3.75 to 3.90. In the *psychological* component, competence, and impact were the strongest empowering dimensions with similar scores of 3.84. Registered nurses considered commitment (3.85) empowering within the *positive work behaviour and attitudes* component. The

lower values correlated with the view that nurse managers feel more empowered than registered nurses, as indicated in Table 4.27. There were certain dimensions where both groups obtained low mean scores. For example, managers obtained a low mean score of 2.93 for resources, and registered nurses 2.61- implying that for both groups, resources was not an empowering dimension. In terms of burnout the managers obtained a mean of 2.48 and registered nurses 2.79, indicating that they experienced low levels of burnout which supports Kanter's Theory, that low levels of burnout facilitate the empowerment of employees (Manojlovich 2007:2).

Table 4.27 Differentiation on the views of nurse managers (n=44) and registered nurses (n=207) on being empowered or not being empowered

	Nurse manager				Registered nurse			
	Empowerment category				Empowerment category			
	Not empowered		Empowered		Not empowered		Empowered	
	Mean	Std Dev	Mean	Std Dev	Mean	Std Dev	Mean	Std Dev
Opportunity	3.36	0.71	4.35	0.6	3.50	0.76	4.36	0.54
Information	3.47	0.62	4.34	0.58	3.53	0.76	4.27	0.52
Support	3.15	1.23	4.22	0.71	3.36	0.8	4.18	0.61
Resources	2.70	0.75	3.01	0.83	2.35	0.88	2.92	0.98
Formal power	3.36	0.67	4.05	0.63	3.39	0.79	4.08	0.7
Informal power	3.11	0.69	3.95	0.6	3.44	0.83	4.10	0.65
Meaning	3.58	0.42	4.26	0.63	2.95	1.01	3.88	0.9
Competence	3.25	1.07	4.14	0.76	3.52	0.91	4.20	0.53
Autonomy	3.36	0.44	4.18	0.55	3.40	0.77	4.01	0.58
Impact	3.16	0.9	4.12	0.76	3.52	0.88	4.22	0.64
Commitment	3.27	0.96	4.12	0.77	3.58	0.94	4.16	0.71
Low stress	2.98	0.92	3.82	0.8	3.24	0.8	3.83	0.77
Low burnout	2.80	0.73	2.37	0.65	2.89	0.77	2.67	0.81
Organisational structure	3.61	0.55	4.18	0.62	3.21	0.78	3.88	0.84

In Table 4.27 the empowerment dimensions are posed against the manager and registered nurse respondents, distinguishing between those respondents who did not feel empowered and those who felt empowered within the two groups.

In considering the results contained in Table 4.27 it is evident that the means of both groups on all dimensions (except for low burnout) were higher for being empowered

than for those perceived as not being empowered. The results in accordance with Kanter's *Theory of Structural Empowerment* will now be summarised.

In the *structural empowerment* component, the lack of proper and sufficient resources in the public health sector is a reality and the least empowering dimension for both nurse managers and registered nurses. The lack of material resources includes the lack of medicines, diagnostic equipment and limited human resources, leading to frustration for staff and patients alike, and poor or delayed patient care and treatment. The lack of resources makes it impossible for nurses to provide quality nursing care, and entails additional expenses for patients who have to return at a later date in the hope of receiving the anticipated treatment and or medication (James & Miza 2012:4). It also causes unease for staff having to apologise when the required resources and promised standard of service are not available (Jooste 2011:275). The lack of resources thus distracts from staff members' feeling of being empowered.

In view of *psychological empowerment*, encompassing meaning, competence, autonomy and impact, the scores for being empowered was consistently higher for both groups (ranging from 4.12 to 4.26 for managers and from 3.88 to 4.22 for registered nurses) than for the respondents who did not perceive themselves to be empowered (3.16 to 3.58 for nurse managers and 2.95 to 3.52 for registered nurses). According to Rawat (2011:146), *psychological empowerment* leads to a feeling of being enabled. It thus appears that the psychological dimensions pertaining to empowerment were in fact enabling factors for the empowerment of both the nurse managers and registered nurses.

Within the scope of *positive work behaviours and attitudes*, Kanter's Theory incorporates four factors namely job satisfaction, commitment, low stress and low burnout as factors that could lead to a sense of being empowered in the work environment. Regan and Rodriguez (2011:104) state that job satisfaction and reduced job stress can be two of the positive consequences of promoting nurse empowerment and can serve to reduce nurse burnout.

As noted before, the questions pertaining to job satisfaction in this study were found to be unreliable by the Cronbach Alpha, therefore the dimension of job satisfaction was not included in the further analysis and presentation of data.

As far as commitment is concerned, both groups of respondents had a higher mean score for being empowered (4.12 for nurse managers and 4.16 for registered nurses), than the respondents who were not perceived to be empowered (3.27 for nurse managers and 3.58 for registered nurses).

This implies that the respondents' identification with their workplace, their involvement in the organisation, and their willingness to put in more effort on behalf of the organisation and in the performance of their tasks and responsibilities were evident in their commitment to positive outcomes which created a sense of success, achievement and empowerment (Rawat 2011:144).

The mean scores of the following two dimensions, namely low stress and low burnout, need to be viewed slightly differently due to the quantification characteristic attached to stress and burnout. Under section 4.6.17 the type of questions in the data collection instrument relevant to these two dimensions was discussed as the positively stated questions for stress and negatively stated questions for burnout affect the interpretation of the results.

Acquiring higher empowering mean scores for the 'low stress' dimension (3.82 for nurse managers and 3.24 for registered nurses) than the non-empowered respondents (2.98 for nurse managers and 3.24 for registered nurses), based on the positively stated questions is indicative that they were treated with respect, and they considered themselves as being responsible (Robbins et al 2010:526), that they were encouraged to develop on a continuous bases, and were allocated tasks in a fair manner. It also indicates managerial respect for employees (Jooste 2011:141), and that conflict is handled effectively. Thus lower levels of stress are experienced which creates an empowering environment.

In contrast, the questions formulated to determine 'burnout' levels, were negatively stated about the following aspects; (judgmental supervision, insufficient time, having to work overtime, noisy environment, high workload and tempo and no authority).

Thus disagreeing to these negative statements, indicates that burnout was in fact not a serious problem based on the stated variables from which the deduction can be made

that ‘low’ levels of burnout are instrumental in promoting a good empowering work environment as Kanter’s theory postulates (Cavus & Demir 2010:69).

The two additional factors which are not part of Kanter’s theory, but which were discussed under section 4.6.1 is empowerment which dealt with empowering activities the respondents were permitted to perform, and organisational structure discussed under section 4.6.16.

The results of these two factors indicate that the respondents were provided with more empowering activities which made them feel empowered, they participated in decision-making and they used problem-solving skills to deal with their unit challenges even though some of the respondents felt less empowered with policy formulation. Table 4.26 reveals that nurse managers scored a mean of 4.10 with empowerment whereas registered nurses scored a mean of 3.48 which indicates that nurse managers felt more empowered than registered nurses in this regard. However, empowerment as a concept in Table 4.22 obtained a mean score of 3.59 which is below the level for empowerment which was set at 3.75.

In relation to ‘organisational structure’ the mean score of the empowered respondents (4.18 for nurse managers and 3.88 for registered nurses) was higher than the mean scores for the non-empowered respondents (3.61 for nurse managers and 3.21 for the registered nurses). This indicates that organisational factors such as the delegation of authority to take work-related decisions, to apply disciplinary measures and handle grievances, are important empowering factors for the respondents.

4.11 CONCLUSION

Data analysis and interpretation of results were discussed in this chapter. The first section included the purpose of the study, the objectives of the study and the data analysis process and data analysis tests.

Section 2 focused on the descriptive information of the respondents’ response rates per hospital and the biographic profile of the respondents: the respondents’ current positions within the hospitals, distribution of respondents per position, respondents’ gender and age distribution, and included the response rate per hospital.

The third section dealt with the 14 dimensions of Kanter's *Theory of Structural Empowerment* plus the concept of empowerment and organisational structure, totaling 15 dimensions (thus excluding job satisfaction). The results were discussed according to the dimensions of empowerment. The theory is divided into *structural empowerment* that includes the dimensions of opportunity, information, support, resources, formal power and informal power; and *psychological empowerment* that includes the dimensions of meaning, confidence, autonomy and impact. *Positive work behaviours and attitudes* include job satisfaction, commitment, low stress and low burnout as dimensions. The three components and their related dimensions were used to structure the discussion of the data. In this study the results indicate that even though most of the respondents felt empowered, there were respondents who were still experiencing powerlessness. The last section focused on the outcome of the inferential statistics. The summary, conclusions, recommendation and the empowerment guidelines of this study are discussed in Chapter 5.

CHAPTER 5

SUMMARY, CONCLUSIONS AND DEVELOPMENT OF GUIDELINES

5.1 INTRODUCTION

The focus of the study was to look at the empowerment of nurses. A quantitative approach with an exploratory and descriptive research design was used to conduct the study. The population consisted of nurse managers and registered nurses working in public hospitals of the Ehlanzeni district within the Mpumalanga Province. Conclusions were drawn and recommendations were made for nurse managers, registered nurses and for further research. The chapter presents a summary of the findings, conclusions and limitations and provides guidelines for enhancing the empowerment of nurse managers and registered nurses.

The purpose of the study was to determine what empowerment encompasses, and to establish the reasons for the perceived lack of empowerment of registered nurses. Furthermore, its purpose was to develop guidelines that managers could apply in order to enhance the empowerment of registered nurses in their service, and in turn, to cultivate confident nurse leaders.

5.2 OBJECTIVES

The objectives of the study were to

- describe what empowerment entails, and determine the effect of empowerment on professional conduct in the workplace
- explore the level of empowerment among nurse managers and registered nurses
- ascertain the effect of powerlessness on the professional conduct and behaviour of nurse managers and registered nurses
- establish the reasons for the perceived lack of empowerment among nurse managers and registered nurses
- determine whether there is a difference in the way in which nurse managers and registered nurses perceive empowerment in their organisations

- develop empowerment guidelines for nurse managers and registered nurses

A study of this nature has never been conducted within the Ehlanzeni District of the Mpumalanga Province, namely to evaluate whether nurse managers and registered nurses were empowered or not. Kanter's *Theory of Structural Empowerment* was used as a theoretical framework for this study.

5.3 SUMMARY OF CHAPTERS

Chapter 1 provided an overview of the study. It included the background of the study that highlighted some of the factors that were believed could have contributed to the perceived disempowerment among nurse managers and registered nurses. The main research problem for this study was the apparent lack of empowerment among registered nurses in public hospitals of a district in the Mpumalanga Province, and the effect thereof on their functioning. The literature reviewed on the subject showed that managers needed to ensure that work environments were conducive to professional and personal growth for nurses. Chapter 1 also introduced the theoretical framework on which the study was based, namely Kanter's *Theory of Structural Empowerment.* A more detailed description thereof was given in Chapter 2. The following aspects were also included in Chapter 1: goals and the objectives of the study, definition of key concepts, research methodology, ethical principles, permission to undertake the study and the structure of the thesis.

Chapter 2 focused on the literature review concerning empowerment. In this chapter, the theoretical framework used in the study was described, and the value of a theoretical framework was described. Kanter's Theory of Structural Empowerment is divided into three components, the first being *structural empowerment*, which includes the dimensions of opportunity, information, support, resources, formal power and informal power. The second component is concerned with *psychological empowerment* which includes meaning, competence, autonomy and impact as dimensions. Component 3 is concerned with *positive work behaviours and attitudes* and includes job satisfaction, commitment, low stress and low burnout as dimensions. Kanter's *Theory of Structural Empowerment* emphasises the importance of giving power to employees in order for them to accomplish their tasks.

Chapter 3 discussed the research methodology. A quantitative approach, with an exploratory and descriptive research design, was used. A structured self-developed questionnaire was used to collect data. The population consisted of nurse managers and registered nurses. The research instrument was discussed in detail in this chapter. The validity and reliability of the instrument was assessed by a professional statistician, the supervisor and the co-supervisor from the Department of Health Studies at UNISA and a group of experts in the field of the study. All the different concepts included in quantitative research methodology were discussed.

Chapter 4 dealt with the analysis and interpretation of the collected data. The first section focused on Table 4.1 which described the respondents' sampling population per hospital; followed by the participating hospitals. This chapter also focused on the biographical profile of the respondents.

The second section concentrated on the interpretation of the experiences of all the respondents concerning empowerment. The three components of Kanter's *Theory of Structural Empowerment* were used to interpret the data collected from the respondents. These components are: *structural empowerment*, *psychological empowerment* and *positive work behaviours and attitudes.* Two concepts that do not form part of Kanter's Theory were also used namely empowerment and organisational structure to gain the opinion of respondents.

The tables in Chapter 4 − Tables 4.21, 4.22, 4.23, 4.24 and 4.25 − were used to interpret the feelings of the respondents by using the Analysis of Variance (ANOVA) in order to determine the level of empowerment of both groups of respondents. Open-ended questions were used to give the respondents the opportunity to express their views on empowerment related aspects, in writing.
In Chapter 5, the researcher drew conclusions from the findings of the study, and developed the empowerment guidelines to address the dimensions that were found to be non-empowering.

5.4 SUMMARY OF EMPIRICAL FINDINGS

From the 884 questionnaires, 267 were returned representing a 30.2% response rate. The following section focuses on the summary of findings generated from data collected

from the 267 respondents. It is disconcerting that for most of the aspects tested in the questionnaire the 'neutral' response per item was high, ranging from 6.5% to 29.6%, but mostly ranging between 10 and 20 percent. According to Edward and Smith (2014:2), respondents choose 'neutral' responses because they do not want to indicate their undesirable opinion regarding the items in the questionnaire.

The summary of the empirical findings are presented in the following sequence taking note of the components of Kanter's *Theory of Structural Empowerment:*

- Biographical information
- Structural empowerment
- Psychological empowerment
- Positive work behaviours and attitudes
- Empowerment
- Organisational structure
- Inferential statistics

5.4.1 Biographical information

The next section focuses on the biographical information of the respondents.

- **Distribution of respondents per position**

The respondent population consisted of 207 (82.5%) registered nurses and 44 (17.5%) nurse managers.

- **Respondents' tenure in current position**

Just more than a quarter (n=68; 26.7%), of the respondents had served in their current position for 6-10 years. With six years' and longer experience in a position, it can be assumed that these nurses were familiar and confident in their positions, understanding the organisational culture and the way management of the institution and its staff was conducted. The respondents whose tenure falls between 1-5 years comprised of 62

(24.3%) which might indicate that some may be new appointees and others may have been promoted to a managerial position within the last five years.

- **Respondents' gender**

The majority of the respondents − 238 (92.2%) − were females and 20 (7.8%) were males. These numbers are in line with the statistics obtained from the South African Nursing Council, which was released on 5 January 2016 (the provincial distribution of nursing manpower versus the population of South Africa**)** which indicates that the nursing profession is highly constituted of females. The total number of registered nurses in South Africa is 136 854, of which 124 399 (90.9%) are female nurses and 12 455 (9.1%) are male nurses.

- **Age of the respondents**

The majority of the respondents (n=227; 88.3%) were aged between 36 and 56+ years and the other respondents' ages ranged from 21 to 35 years (n=30; 11.7%). This indicates that most of the respondents were older than 35 years, thus having a certain measure of professional and life experience and a personal understanding of what affects them being empowered or not.

5.4.2 Structural empowerment

The *structural empowerment* component of Kanter's Theory encompasses six dimensions, namely opportunity, information, support, resources, formal power and informal power. A summary of these results will now be provided.

5.4.2.1 Item 6.1: Opportunity dimension

In view of receiving opportunities for growth and development, the requests of 230 (87.5%) respondents were considered during work scheduling, 205 (78.5%) received coaching from their supervisors, 202 (79.5%) were delegated challenging tasks, 198 (76.7%) could participate in management decisions, and 194 (74.0%) could attend work-related seminars. The strong positive responses indicated that the respondents received opportunities for growth and development. These results are supported by

Kanter's Theory which suggests that employees should be provided with opportunities to advance within the health care organisation (Miller et al 2001:3).

5.4.2.2 Item 6.2: Information dimension

Under this second dimension of *structural empowerment*, 222 (85.4%) respondents were allowed to make inputs regarding their tasks and responsibilities, 216 (82.1%) were provided with new information that they needed to carry out their duties, 207 (79.9%) considered their job descriptions relevant to their job, 205 (78.2%) received orientation with regard to new policies and organisational procedures, 194 (74.3%) received regular feedback from their supervisors and 184 (72.4%) gained from their supervisors' sharing their experience and expertise with the respondents.

The positive results pertaining to gaining information points to the empowerment of the respondents enabling them to make informed work-related decisions to accomplish organisational goals, and promote two-way communication during feedback sessions. The results are in line with Kanter's view which indicates that access to information is an important means of acquiring knowledge, understanding organisational practices, policies and procedures that are required for effective functioning accompanied with the authority of knowing what to do (Lucas et al 2008:965).

5.4.2.3 Item 6.3: Support dimension

As for support, the third empowering dimension under *structural empowerment* , 203 (78.7%) respondents benefitted from their supervisors listening to their concerns and receiving clear directions when tasks were delegated, 191 (74.0%) could use their analytical skills in solving problems, and suggestions of 187 (73.0) were considered by their seniors. Recognition for work well done was noted by 155 (59.6%) respondents, but almost a quarter, 62 (23.8%) did not receive any acknowledgement for good work. The mostly positive responses received in respect of the support dimension indicate that the respondents were empowered. However, a quarter of the respondents did not receive recognition, which could be demoralising.

5.4.2.4 Item 6.4: Resources dimension

This is the first dimension of Kanter's Theory, within the *structural empowerment* component, where all the responses to the different items were more negative than positive. One hundred and thirty-eight (52.1%) respondents felt that they were not provided with adequate personnel to enable them to meet the organisation's goals, nor were they provided with sufficient supplies (n=116; 43.8%) or equipment (n=109; 41.4%). One hundred and twenty-three (46.6%) disagreed that their inputs were requested when the operational budget had to be compiled. Almost a similar number of respondents indicated that meeting times were not exceeded (n=101; 38.8%) in comparison with 99 (38.1%) who agreed that the time allocated for meetings was exceeded.

The neutral responses to these items ranged from 15.2% to 27.4%. One would have thought that the respondents would have a definite view on whether there were sufficient resources or not as it affected them directly on a daily basis. The information gained from the relevant open-ended question indicated a lack of material resources and equipment such as electrocardiogram machines, and staff shortages which related to doctors, registered nurses and auxiliary nurses, posing a barrier to their effective functioning.

In order to perform one's function, resources are required, especially in service delivery institutions such as hospitals. Sufficient working equipment, stock and supplies enable the execution of nursing staff's patient care and treatment functions leading to a sense of achievement. However, without adequate resources, whether it be personnel, equipment or medication, even the most empowerment-oriented organisation can lose its focus (Hardina et al 2007:62).

It is therefore evident that the negative responses in terms of the availability of resources in the selected hospitals emphasise the difficulties nursing staff have to deal with when attempting to deliver quality patient care. This leads to frustration on their and the patients' part which creates a sense of powerlessness and dissatisfaction (Manojlovich 2007:258), which is not empowering. A study conducted by Mokoka et al (2010:5), indicated that a shortage of supplies and dysfunctional equipment or the lack of equipment were seen by nurse managers as key issues which organisations should

address to enhance retention of staff. This supports the *structural empowerment* component of Kanter's Theory, which considers resources an important empowering dimension.

5.4.2.5 Item 6.5: Formal power dimension

This section focuses on the access to formal power in the workplace. Whereas 199 (76.0%) respondents were permitted to take decisions within the scope of their responsibilities in their nursing units, 191 (72.6%) were aware of the hospitals' goals and objectives and noted that appropriate in-service education programmes were available allowing them to grow professionally and to improve their skills, 181 (70.2%) were allowed to use their discretion in matters relating to their jobs. The use of discretion in clinical practice could be accomplished by not setting up specific rules which employees should follow in each circumstance, thus facilitating individuals to decide on their own on how to solve job-related problems. The supervisors of 163 (62.0%) respondents recognised their developmental needs.

The results show that most of the respondents experienced formal power in accordance with items contained in the questionnaire (decision-making, use of discretion, familiarity with goals and objectives and access to training opportunities). This fifth item contained in the *structural empowerment* component of Kanter's *Theory Structural Empowerment* is usually dependent upon the position a person holds, as formal power allows the person to plan and direct the work of subordinates towards goal achievement. Acting according to one's knowledge and judgment, provides a sense of being in control and illustrates the autonomy a person has (Weston 2012:2), which engenders a feeling of being empowered.

5.4.2.6 Item 6.6: Informal power dimension

Regarding gaining informal power in the workplace, 221 (84.4%) of the respondents indicated sharing their knowledge with other nurses in order to empower one another. The supervisors of 181 (69.3%) respondents considered their contributions, and respected the expertise they exhibited at work (n=170; 64.9%). Interaction with other nurses associated with and through professional organisations, was encouraged by the supervisors of 165 (62.5%) so that professional networks could develop. The fact that

131 (49.6%) of the respondents indicated that their supervisors did not access sponsors in order to present work-related seminars, could be due to the inappropriateness of the question. Normally developmental programmes are planned and arranged by a specific department/section within the nursing division or health service and clinical supervisors are not required to search for sponsors.

Informal power is the sixth dimension under *structural empowerment* of Kanter's theory. Within the work context informal power pertains to the relationships or alliances people cultivate and build with colleagues, peers and other role players (Smit et al 2011:224). Informal power is not generated by the employer, but achieving informal power by means of the association with other persons who are considered to be important, visible or in leadership positions, also enhances the visibility and influence of the less senior position, thus creating a feeling of being empowered as one's ideas are considered and interaction with important others are observed. Miller, Goddard & Laschinger (2001:2) support the view that Individuals can access informal power from the alliances they form within the organisation, superiors and peers as well as with subordinates.

The mostly positive results obtained from the items of the 'informal power' dimension are indicative that at least two-thirds of the respondents experienced some form of informal power (through sharing knowledge, professional networking, and recognition of contributions and expertise).

5.4.3 Psychological empowerment

Psychological empowerment is the second component of Kanter's Theory and is divided into four dimensions, namely meaning, confidence, autonomy and impact. These dimensions are discussed in the next section. *Psychological empowerment* is seen as an essential component of workplace empowerment, representing intrinsic task motivation, or employee rewards that are inherent to empowering work conditions (Wagner et al 2010:449).

5.4.3.1 Item 7.1: Meaning dimension

Meaning related to work, refers to the congruence between a person's beliefs, values, behaviours and job-related requirements (Laschinger et al 2009:229). In this instance,

the aim was to determine whether the respondents perceived their work as meaningful in line with the items posed in the questionnaire. Two hundred and forty- six (93.2%) of the respondents considered themselves to be competent in the manner they executed their duties, 212 (81.9%) were of the opinion that they could identify conditions which fostered powerlessness, 163 (62.0%) were permitted to express their beliefs and values within the work area, and 154 (59.2%) were allowed to set goals for their units. However 59 (22.4%) disagreed that their supervisors appreciated and supported the goals set by the respondents.

A feeling of meaningfulness is supported by the incumbents knowing and having acknowledged that their work is important and that their inputs are valuable (Stander & Rothmann 2010:3). So being able to set the relevant objectives, having them supported by their supervisors and being given the opportunity to express their beliefs and views in their units allow them to express their self-concept (Stander & Rothmann 2010:3) and support a feeling of being competent and empowered to perform as expected. Being able to recognise and identify aspects that could foster powerlessness is an indication that the respondents are informed and aware of conditions that hold them back from being fully empowered. In line with items posed to test this first dimension under *psychological empowerment*, the respondents appear to experience a sense of meaningfulness with regard to their work.

5.4.3.2 Item 7.2: Competence dimension

Competence which replaced ‘confidence’ in this study as put forward by Kanter’s Theory (refer to Chapter 2, section 2.3.2 for an explanation) is applied as the second dimension of *psychological empowerment*. Competence refers to the ability to utilise one’s knowledge and skills appropriately to perform one’s task and responsibilities while displaying a positive and confident attitude (Rawat 2011:143). In this study the supervisors of 225 (84.6%) respondents took into account their capabilities when allocating tasks, thereby acknowledging their competence (n=210; 79.8%), and delegating the necessary authority to perform the tasks (n=207; 78.4%). This engenders assertive behaviour, allowing one to speak out about one’s rights in the environment (n=192; 73%) and encourages participation in developmental activities after performance appraisals (n=145; 54.9%). One hundred and forty-one (53.0%) of the

respondents were required to perform tasks that were not covered by their scope of practice.

According to the results, the positive responses to the stated items are indicative that the respondents feel confident and competent about their work responsibilities, are able to perform as required, can be assertive when needed, and even do tasks that are not covered by their scope of practice. They thus appear empowered to do what is expected of them and they have their supervisors' support. This is supported by Ergeneli et al (2007:43) who note that competence is the belief that individuals are able to perform their task activities skillfully. Being delegated the necessary authority together with the task, engenders competence and empowers the individual to make the necessary decisions (Armstrong et al 2013:100).

5.4.3.3 Item 7.3: Autonomy

Autonomy refers to the ability and freedom to act according to one's knowledge and judgment without having to acquire permission to do so. This is supported by the supervisors of 205 (77.7%) respondents who allowed them to control work conduct in their units, encouraged them to do their best (n=211; 80.2%), allowed them discretional power to allocate tasks to subordinates (n=205; 78.8%), gave them autonomy in determining the outcomes of their units (n=148; 56.1%) and actively cultivated autonomy in the organisation (n=133; 56.2%). Forty-five (17.8%) respondents did not agree that autonomy was cultivated in their organisation.

The results indicated that respondents were given autonomy to act independently when performing their delegated duties. Abraiz et al (2012:394), state that team members become motivated when the activity they perform offers group members considerable autonomy for making a decision about how they do the work. The results also suggest that the respondents were allowed to use their discretion to control job-related decisions which encourages a sense of responsibility in employees. The third dimension under *psychological empowerment*, autonomy, appears to be well developed and applied amongst the respondents as they could delegate, use their discretion and control the work performance in their units.

This would give them a sense of being in control, thus having the power to manage their units as they saw fit. The findings of the research study conducted by Weston (2010:2) on the strategies for enhancing autonomy and control over nursing suggest that nursing work environments with higher levels of autonomy were associated with increased performance and improved patient outcomes; this indicated that higher nurse autonomy and control was found to be associated significantly with improved quality patient outcomes.

5.4.3.4 Item 7.4: Impact dimension

Impact refers to the influence and effect one's inputs have on the outcome of work, organisational systems and administrative and operating outcomes, thus the difference one's input makes. The responses to the five items relevant to impact were all positive. The supervisors of 211 (80.5%) respondents encouraged professional interaction to improve nursing care, provided constructive feedback (n=203; 76.6%), acknowledged their contributions to patient wellbeing (n=201; 75.6%) listened to the ideas of subordinates (n=188; 70.9%), and recognised their ability to influence job outcomes (n=179; 69.6%).

Stander and Rothmann (2010:3) purport that impact involves the accomplishment that one experiences when goals have been achieved and it is evident that others listen to one' ideas and views. The respondents were of the opinion that they were making a positive difference by proposing new ideas, contributing to patient wellbeing, influencing job outcomes and interacting with colleagues to improve patient care. Consequently, as the fourth and last dimension of *psychological empowerment*, impact appears to be relevant in the empowering process as the respondents were aware of how they positively influenced the outcomes in the workplace, and this gave them a sense of being recognised and empowered.

5.4.4 Positive work behaviours and attitudes

Positive work behaviours and attitudes is the third component of Kanter's Theory. This section deals with the dimensions that form part of this component, namely job satisfaction, commitment, low stress and low burnout.

5.4.4.1 Item 8.1: Job satisfaction dimension

Job satisfaction refers to a person's general attitude towards his or her job, and the measure of enjoyment derived from one's job (Jacobs & Roodt 2008:66). The number of neutral responses to the items pertaining to this dimension was high, ranging from 10.1 to 17.5 percent. Positive responses were that 205 (79.8%) respondents found their supervisors approachable, 151 (57.6%) worked in a climate free from harassment and 114 (43.3%) disagreed that they were expected to regularly perform non-nursing duties. One hundred and thirty-nine (53.1%) respondents disagreed that their work climate was not challenging, in other words, they found their work climate challenging, and 128 (48.3%) respondents indicated that they did not receive a fair salary, whereas 79 (36.6%) agreed that they received a fair salary. Job satisfaction is the first dimension within the *positive work behaviours and attitudes* component of Kanter's Theory. According to this theory, job satisfaction is an empowering dimension, as a positive feeling about one's work leads to aspirations for doing better, growing and developing through critical introspection thereby reaching higher levels of self-evaluation, and to a feeling of being empowered (Crossman & Pfeil 2013:8).

5.4.4.2 Item 8.2: Commitment dimension

According to Rawat (2011:144), commitment refers to an individual's identification with, and involvement in, the organisation, characterised by a strong belief in, and acceptance of the organisation's goals and values to such an extent that there is a willingness to exert considerable effort on behalf of the organisation. Most of the responses to the five items measuring the commitment of the respondents' supervisors were positive. The supervisors of 206 (77.4%) respondents were committed to effective patient care, 200 (75.5%) ensured the presentation of relevant in-service training sessions, 199 (74.5%) ensured effective utilisation of resources, 146 (56.4%) used a leadership style which engendered commitment among nurses and 119 (45.4%) assisted subordinates in their preparation for promotions.

As the second dimension of *positive work behaviours and attitudes*, commitment of the respondents' supervisors appeared to be well established as these supervisors displayed a positive leadership style, were committed to patient care, saw to the

effective utilisation of resources and to proper in-service training, thus serving as positive role models in their motivation to exert effort on behalf of the organisation. When employees work in environments that encourage inclusiveness in decision-making and administrative processes, employees perceive them as promoting high job satisfaction and enhancing performance (Gormley & Kennerly 2009:110).

5.4.4.3 Item 8.3: Low stress dimension

Huber (2010:131) postulates that stress is a physical, mental, psychological, or spiritual response to a stressor. The supervisors of 186 (70.3%) respondents handled conflict within the ward/unit in a timely and effective manner and 187 (70.3%) allocated tasks according to the individual's abilities, 173 (65.8%) respondents were treated with respect by their seniors and for 146 (55.5%) lifelong learning was promoted in the organisation through career development plans for individual employees (n=135; (50.8%). On the negative side, 77 (28.9%) of the respondents indicated that their organisations did not have career plans for every employee and 180 (67.9%) felt they were overloaded with work.

Low stress is the third dimension in the *positive work behaviours and attitudes* component of Kanter's theory. As no situation is ever totally stress free, this theory proposes that low stress levels in the work environment reduces job strain and improves employee work satisfaction and performance which engenders an empowering work environment in contrast to the negative consequences of high levels of stress (Davies et al 2011:634).

5.4.4.4 Item 8.4: Low burnout dimension

According to Yoder-Wise (2007:540), burnout refers to a prolonged response to chronic emotional and interpersonal stressors in the job environment. Most of the statements pertaining to low burnout in the questionnaire were negatively formulated, which means disagreeing with the statements provides a positive response. One hundred and forty (54.9%) of the respondents disagreed with working in a noisy environment, 139 (53.3%) disagreed with not being given authority to control job related tasks, 132 (50.8%) did not consider their supervisors as being judgmental and 126 (48.1%) did not have to work overtime on a regular basis. In view of not having sufficient time to attend to their

patients' needs, 126 (47.5%) disagreed with this statement, but 115 (44.4%), stated that their workload was so high that they never seemed to catch up with everything they needed to do, which seems to contradict each other.

Low burnout, being the fourth and last dimension within the *positive work behaviours and attitudes* component of Kanter's Theory, is similar to low stress in the sense that one would wish burnout not to be present amongst the employees of an organisation, but it may well be evident especially in caring professions such as health services. For example stress in the nursing profession is believed to be caused by physical labour, demands of patients and their families, long working hours, shift work, interpersonal relationships (inter-and intra-professional conflict) and other pressures that are part of the nurses' work (Roberts, Grubb, & Grosch 2012:1).

In considering the moderately positive results acquired for the dimension of low burnout, it appears that burnout amongst the respondents was in fact low because they did not work overtime on a regular basis, their work environments were not noisy, their supervisors were not judgmental and they could control job-related tasks in the area of work. The workload and work tempo was however a concern for slightly less than half of the respondents.

5.4.5 Item 9.1: Organisational structure

The concept 'organisational structure' does not form part of the dimensions of Kanter's Theory. However the organisational structure is an important entity in the empowerment of employees as it delineates the relationships and lines of authority and communication in the organisation.

An empowering organisational structure allows nurses to participate in the organisation's decision-making (Gilbert et al 2010:340). For example, such an organisational structure should include nurses along with physicians and administrators in committees where decisions are made that develop patient care policies and procedures (Weston 2010:5).

One hundred and eighty-five (70.1%) of the respondents indicated that they were given the authority to act according to their post levels, while 153 (58.6%) were also given

authority to institute disciplinary measures against their subordinates, whereas 71 (27.2%) were not given this authority. One hundred and eighty (69.0%) were given the right to initiate a grievance process when aggrieved, 171 (70.1%) indicated that their supervisors adhered to an open-door policy, and 146 (55.5%) said they did not have more than 15 subordinates reporting to them.

The results indicated that the majority of the respondents were given power to control their job-related activities in their wards/units. The respondents were also given the authority to act according to their post levels. The implementation of the open-door policy facilitated two-way communication between supervisors and employees. It appears that the respondents felt empowered with regard to the items posed relating to organisational structure within the institution. The results suggest that positional power becomes high when jobs are seen at the centre of the achievement of organisational goals, and when employees are allowed to exercise flexibility in how they can accomplish delegated tasks (Smith et al 2010:1005).

5.5 SUMMARY OF EMPIRICAL FINDINGS BASED ON INFERENTIAL STATISTICS

The next section focuses on a summary of the findings of the research study that are based on the inferential statistics. The interpretation of the results is arranged according to the dimensions of Kanter's *Theory of Structural Empowerment*.

5.5.1 Mean average scores of each empowerment dimension

Mean scores of each empowerment dimension are discussed in the following section that focuses on each dimension of *structural empowerment*, *psychological empowerment, positive work behaviours and attitudes,* and the concepts of empowerment and organisational structure.

5.5.1.1 Structural empowerment

Table 4.22 exhibits the combined mean scores for the two groups of respondents' views on their level of empowerment, as indicated per dimension. The median 3.75 of these scores was used as a cut-off point by which to differentiate between the respondents

who felt empowered and those who felt not empowered. The respondents who scored from 3.75 and above were categorised as being empowered, and those below 3.75 were categorised as being not empowered.

Seven of the 15 scores were 3.75 or above, indicating that the respondents felt empowered in seven dimensions. The dimensions that the respondents felt empowered about under the *structural empowerment* component of Kanter's *Theory of Structural Empowerment* are the receiving of opportunities for growth and development (3.94), information (3.93) and support (3.77). The lowest score under this component was for resources (2.75) which indicated that the respondents did not have the required resources to execute their responsibilities. Resources include human resources, equipment, and supplies. Smit et al (2011:4), indicate that managers have the responsibility of bringing together and deciding which resources are needed for the achievement of the organisation's goals.

The results under *structural empowerment* suggest that the respondents also felt less empowered with formal (3.73) and informal power (3.52). Formal power which is usually associated with one's position is evident in one being permitted to use one's discretion, to make work-related decisions and organise work accomplishment (Robbins et al 2010:506). Having formal power would engender a sense of being empowered. Formal power could be achieved by allowing the respondents to use their discretion and by the identification of the respondents' developmental needs and ensuring that development plans are designed to meet the needs of the employees (Meyer et al 2009:298). Informal power is not created by the formal structure within an organisation, but has to do with the interaction and associations employees make in creating social networks and power groups**.**

5.5.1.2 Psychological empowerment

Psychological empowerment is the second component of Kanter's Theory. These components consist of four dimensions, namely meaning, confidence, autonomy and impact.

Within the *psychological empowerment* component of Kanter's Theory, all four dimensions scored above 3.75, indicating that meaning (3.78), competence (3.75), autonomy (3.77), and impact (3.84) were considered empowering dimensions.

5.5.1.3 Positive work behaviours and attitudes

There are four dimensions under *positive work behaviours and attitudes*. The items measuring job satisfaction as a dimension were considered to be unreliable, therefore job satisfaction was not used in further analysis.

The remaining three dimensions all scored less than 3.75, namely commitment (3.63), low stress (3.56), and low burnout (2.76). The fact that low stress and low burnout scored less than the median of 3.75 is indicative that the respondents in actual fact experienced low levels of stress and burnout which is conducive to an empowering environment. The score of 2.76 for low burnout in relation to empowerment is congruent with the findings of Ebrahim et al (2013:3454) who indicate that nurses experienced less burnout as long as they felt themselves powerful.

5.5.2 Organisational structure

Organisational structure as a concept does not form part of Kanter's *Theory of Structural Empowerment.* However it is important to address this concept since it is through organisational structure that employees can effectively and efficiently accomplish the goals and objectives of the organisation. It shows how responsibilities are delegated and communication channels are drawn.

Within the organisational structure, a mean score of 3.42 was obtained which is below 3.75; this indicates that organisational structure was not considered to be an empowering feature by the respondents.
The following section is concerned with the interpretation of the results as indicated in Table 4.23. The discussions of the findings are arranged according to the dimensions of Kanter's Theory.

5.5.3 Distinguishing between non-empowered and empowered scores

Table 4.23 discriminates between the mean scores of each dimension by signifying at what level the dimension is considered to be non-empowering (<3.75) and empowering (>3.75) respectively.

5.5.3.1 Structural empowerment

Within the *structural empowerment* component of Kanter's Theory, five of the six dimensions were empowering with a mean comparative score above 3.75, namely opportunity (4.35 versus 3.49) (the latter being the non-empowering mean), information (4.28 versus 3.54), support (4.17 versus 3.33), formal power (4.06 versus 3.38) and informal power (4.05 versus 3.43).

Resources scored the lowest (2.98 versus 2.40). Its upper 'empowering' value does not even meet the median of 3.75 which served as the criterion for differentiating between being empowering or not.

5.5.3.2 Psychological empowerment

Within the *psychological empowerment* component, respondents represented by these mean scores felt empowered in regard to all the dimensions namely, meaning (3.97 versus 2.99), competence (4.19 versus 3.47) autonomy (4.05 versus 3.38), and impact (4.19 versus 3.46).

5.5.3.3 Positive work behaviours and attitudes

For the dimensions of *positive work behaviours and attitudes*, the mean scores of the empowered category were 4.14 versus 3.54 for commitment, low stress 3.83 versus 3.20, and for low burnout, 2.63 versus 2.90. The lower score for low burnout is due to the negative phrasing of questions and indicates that the empowered category of respondents experienced low or less burnout symptoms.

5.5.4 Organisational structure

In distinguishing between the respondents who were empowered and those who were not or were less empowered by the organisational structure, the mean score of 3.97 versus 3.25 as non-empowering indicates that organisational structure was considered to be an empowering variable by the respondents. This is in contrast to the score of 3.42 exhibited in Table 4.22 which purely looked at the mean scores of the noted dimensions.

5.5.5 Mean scores of the empowerment dimension per respondent group

The following section deals with the mean scores of the empowerment dimensions as perceived by nurse managers and registered nurses which are presented in Table 4.26. The scores of nurse managers are given for each dimension followed by those of the registered nurses. This information provides the measure of empowerment or lack thereof, as experienced by the two groups of respondents respectively.

5.5.5.1 Structural empowerment

- Empowerment: 4.10 versus 3.48, indicating that nurse managers felt more empowered by empowering activities than registered nurses.
- Opportunity: 4.10 versus 3.90 indicating that the registered nurses experienced opportunities less empowering than the nurse managers
- Information: 4.12 versus 3.88, showing that information was more empowering for nurse managers than registered nurses.
- Support: 3.96 versus 3.74. These scores indicate that nurse managers experienced support more empowering than did the registered nurses.
- Resources: 2.93 versus 2.61. These scores suggest that the resources dimension was not empowering for both the nurse managers and registered nurse groups.
- Formal power: 3.88 versus 3.70, indicating that nurse managers had more ‘formal power’ than registered nurses did.

- Informal power: 3.74 versus 3.75. The results show that registered nurses viewed informal power as slightly more empowering than the nurse managers did, which can be expected in view of their position.

5.5.5.2 Psychological empowerment

- Meaning: 4.09 versus 3.37. Nurse managers experienced meaning as more empowering whilst registered nurses felt less so.
- Competence: 3.91 versus 3.84. Competence was empowering for both groups, however, nurse managers considered competence more empowering than the registered nurses did.
- Autonomy: 3.98 versus 3.68. Nurse managers felt more empowered by having autonomy than the registered nurses did.
- Impact: 3.88 versus 3.84. The mean scores indicate that both groups considered the impact they made in their work environment empowering, but nurse managers deemed it slightly more empowering than registered nurses.

5.5.5.3 Positive work behaviours and attitudes

- Commitment: 3.91 versus 3.85. Both groups considered commitment an empowering dimension, although nurse managers felt more empowered by being committed than registered nurses did.
- Low stress: 3.61 versus 3.51, indicating that nurse managers experienced less stress than registered nurses did.
- Low burnout: 2.48 versus 2.79, indicating that nurse managers experienced less burnout than registered nurses did.

5.5.6 Organisational structure

- Organisational structure: 4.04 versus 3.52. Nurse managers were more empowered by the organisational structure than registered nurses were.

5.5.7 Distinguishing between non-empowerment and empowerment scores for the two categories of respondents

In accordance with Table 4.27 differentiation takes place in view of the two groups of respondents and those being empowered as opposed to those being non-empowered pertaining to each of the dimensions in each group. In the following discussion, the focus will be on the empowered scores and not on those representing the non-empowered levels.

5.5.7.1 Structural empowerment

In view of the above comparison, the levels of empowerment for the dimensions under *structural empowerment* are provided for the nurse managers followed by those of the registered nurses:

- Opportunity: 4.35 versus 4.36, indicating that the registered nurses viewed opportunities slightly more empowering than the nurse managers.
- Information: 4.34 versus 4.27, where the nurse managers considered information more empowering than the registered nurses did.
- Support: 4.22 versus 4.18, showing that for nurse managers support was a stronger empowering factor than it was for registered nurses.
- Resources: 3.01versus 2.92, reflecting that nurse managers scored higher than registered nurses, implying that nurse managers benefitted more from resources in an empowering sense than the registered nurses did.
- Formal power: 4.05 versus 4.08, indicating that formal power was an empowering dimension for both nurse managers and registered nurses. Both groups experienced positional power in their areas of work.
- Informal power: 3.95 versus 4.10, showing that for registered nurses informal power was more empowering than it was for nurse managers.

5.5.7.2 Psychological empowerment

- Meaning: 4.26 versus 3.88, indicating that meaning was more empowering for nurse managers than for registered nurses.

- Competence: 4.14 versus 4.20, showing that competence was considered slightly more empowering by the registered nurses than by the nurse managers.
- Autonomy: 4.18 versus 4.01, indicating that nurse managers experienced autonomy slightly more empowering than registered nurses did.
- Impact: 4.12 versus 4.22, indicating that the registered nurses appeared to be more empowered by the impact they made than did the nurse managers.

5.5.7.3 Positive work behaviours and attitudes

- Job satisfaction was not included in the analysis because the items measuring this dimension were found to be unreliable.
- Commitment: 4.12 versus 4.16, indicating that the registered nurses viewed commitment slightly more empowering than the nurse managers did.
- Low stress: 3.82 versus 3.83. These scores indicate that both nurse managers and registered nurses experienced less stress as empowering.
- Low burnout: 2.37 versus 2.67, indicating that the registered nurses perceived low burnout as slightly more empowering as the nurse managers did.

5.6 GENERAL CONCLUSIONS REGARDING THE RESEARCH FINDINGS

This section focuses on the conclusions of the research findings. The findings will be discussed by making use of the three components of Kanter's Theory, namely *structural empowerment, psychological empowerment* and *positive work behaviour and attitudes* and the added two dimensions of empowerment and organisational structure, which do not form part of Kanter's Theory. The views/experience of the respondents were analysed and were thereafter presented in the form of tables. The components of Kanter's Theory were used to draw the conclusions of the study.

- **Empowerment**

Table 4.6 indicates that the respondents were allowed to use their problem-solving skills, were involved in participative management activities, were allowed to make decisions related to their units' functioning, and some were involved in policy-making. Some of the respondents felt that they were not involved in policy development

processes and decision-making. They felt that decision-making was unfair. Some leaders used a telling style of leadership. The results indicate that the majority of the respondents experienced empowerment in their hospitals by the activities they were permitted to perform, but not all of the respondents felt empowered.

- **Structural empowerment**

Opportunity dimension

Table 4.7 shows that the majority of the respondents received opportunities in their workplace. The opportunities received by the respondents included opportunities for growth and development, delegation of challenging tasks, and being coached by their supervisors when they were uncertain about certain tasks or functions. They participated in management decisions in the area of their responsibilities. The respondents also received in-service training and they were mentored until they were able to perform the tasks well. Even though the majority of the respondents received opportunities in their nursing units, some of the respondents (n=33; 12.8%) did not receive such opportunities. These results indicate that most of the respondents felt empowered by the opportunities they received.

Information dimension

Table 4.8 indicates that the majority of the respondents were provided with information that they needed to perform their job-related responsibilities; they received relevant job descriptions, regular feedback and guidance related to their work. Their supervisors shared their experience and expertise with the respondents which allowed them to grow and to become independent practitioners. The respondents were also oriented with regard to new policies and procedures of their institutions. However, a few (4; 6.7%) of the respondents felt less empowered due to barriers that existed in their institutions, these barriers included inadequate human resources and limited equipment to execute their nursing duties.

Support dimension

According to Table 4.9 most of the respondents received support from their supervisors. The results indicate that the respondents received support in the form of hands-on assistance and the use of analytical skills to solve their units' problems. Their suggestions were considered and they were given clear directions for delegated duties and recognition was given for work well done. Some of the respondents however indicated that they did not receive any recognition for work well done. The results further indicated that respondents who felt that they did not receive recognition could feel less empowered.

Resource dimension

Table 4.10 indicates that the majority of the respondents stated that they were not provided with adequate equipment or adequate personnel that they needed to execute their allocated duties. In response to the open-ended question requiring the respondents to indicate the most important barriers to their performance in the organisation they mentioned shortage of nursing staff, doctors and material resources. The following were indicated by the respondents as resources that might enhance their performance: employment of competent nurses, medical equipment, computers and training in basic computer skills, neonatal training and the allocation of duties according to knowledge and skills.

Formal power

Table 4.10 indicates that the respondents were allowed to use their discretion and to make decisions that were within their scope of responsibilities in their nursing units. The results further indicated that hospitals had in-service education programmes to ensure that their employees grew professionally.

Informal power

Table 4.12 shows that the majority of the respondents experienced informal power because they were allowed to share their knowledge and ideas about patient care with their colleagues and in doing so, they could empower one another. The table also

shows that supervisors respected the expertise that their employees showed when carrying out delegated responsibilities.

The conclusions drawn from the results derived from the *structural empowerment* component of Kanter's Theory indicates that the respondents felt empowered with regard to five of the six dimensions, but felt less empowered regarding the dimension of resources. The lack of resources is contrary to Kanter's Theory which suggests that employees should be provided with the necessary resources in order to experience empowerment in the workplace.

The following section deals with the conclusions pertaining to the dimensions of *psychological empowerment*.

- **Psychological empowerment**

Meaning dimension

According to Table 4.13 the majority of the respondents felt empowered. The respondents indicated that they considered themselves as competent, and able to identify conditions that could lead to powerlessness. Supervisors allowed their employees to express their beliefs and values and supported the goals that they established for their unit.

Competence dimension

Table 4.14 indicates that most of the respondents were given the authority to make decisions related to their responsibilities and to direct the nursing activities of their subordinates. They were also involved in the planning of their developmental activities after receiving feedback on their performance. However, 91 (34.2%) indicated that they were expected to perform tasks that were not within their scope of practice.

Autonomy dimension

Table 4.15 shows that the majority of the respondents felt empowered because they could control the work conduct of their subordinates and determine the outcomes of

their ward/unit. The respondents were also encouraged by their supervisors to perform at their best.

Impact dimension

Table 4.16 indicates that the respondents made a positive impact in their organisations because they interacted with their colleagues to improve nursing practice, they exerted authority by delegating duties to their subordinates, participated in the formulation of policies and protocols and in the planning of in-service training. The respondents further exerted authority by disciplining their subordinates. These results indicate that the workplace promoted the empowerment of employees. Within *psychological empowerment*, the second component of Kanter's Theory, the majority of the respondents felt empowered in the four dimensions.

The next sections provide the conclusions drawn from the findings pertaining to the last component, namely, *positive work behaviours and attitudes*.

- **Positive work behaviour and attitudes**

Job satisfaction dimension

Table 4.17 indicates that there were a high number of neutral responses to questions 8.1.1, 8.1.2, 8.1.3 and 8.1.5. This might indicate that the respondents were reluctant to indicate their opinion regarding these questions. However, the respondents felt that their supervisors were approachable; and their work climate was free from harassment. One hundred and twenty-eight (48.3%) indicated that they did not receive a fair salary, while 97 (36.6%) agreed that they received a fair salary. The results indicate that the respondents experienced a fair amount of job satisfaction.

Commitment dimension

Table 4.18 shows that the respondents reported that their supervisors were committed to the provision of effective patient care, and to the provision of relevant in-service training relevant to the needs of employees. The results also indicate that the respondents felt that their supervisors' leadership style engendered commitment.

Supervisors assisted their subordinates in preparing for their promotions; however 85 (32.4%) respondents did not agree that their supervisors assisted them in preparing for their promotions.

Low stress dimension

Table 4.19 indicates that tasks were delegated according to the respondents' abilities and that supervisors handled conflicts timeously and in an effective manner. The results further indicated that one hundred and eighty (67.9%) nurses were overloaded with work in their nursing units. The reasons cited for the work overload include tiredness, difficulty in taking tea and lunch breaks and shortage of staff. The results show that most of the respondents experienced low levels of stress, even though some of the respondents might have experienced some form of stress due to work overload.

Low burnout

Table 4.20 shows that there were positive and negative responses regarding the experience of burnout, however, it appears that most of the respondents did not suffer from burnout. The respondents indicated that their environments were not noisy and supervisors were not judgmental. The respondents reported that they were given authority to control their job-related tasks. Half of the respondents also stated that they were not required to work overtime regularly. The results indicate a high level (13.7% to 25.8%) of neutral responses in view of the questions posed about low burnout.

The third component of Kanter's Theory is *positive work behaviour and attitudes* (job satisfaction, commitment, low stress and low burnout). The majority of the respondents felt empowered and they experienced low stress, although some felt that they received inadequate salaries, were overloaded with work, and the workload and tempo were so high that they never seemed to catch up with everything they needed to do. With regard to the dimension of burnout the majority of the respondents felt empowered even though some of the respondents were expected to work overtime on a regular basis which might have led them to experience emotional exhaustion which is not in line with Kanter's Theory. The results suggest that some of the respondents might have experienced some form of stress and burnout in the workplace.

The following section focuses on the concepts of empowerment and organisational structure. Organisational structure was included in this study as an important factor in the empowerment of employees.

- **Organisational structure**

According to Table 4.21 the respondents were allowed to act according to their post levels, had authority to give orders to subordinates and were given the right to initiate grievances when aggrieved. The results further indicated that supervisors adhered to an open door policy to allow employees to communicate their needs and concerns to their supervisors. The respondents had less than 15 subordinates in their span of control which indicates that supervisors might have been able to coach them, and give timeous feedback. The results on organisational structure indicate that managers created work environments that empowered the respondents.

The next section describes how the researcher determined whether there was a difference in the ways in which nurse managers and registered nurses perceived the existing empowerment in their organisations.

- **Mean average scores of each empowerment dimension**

Table 4.22 shows that the component of *structural empowerment* was analysed and the results indicated that the respondents felt empowered regarding five of the dimensions except that the dimension of resources was found to be the least empowering. Within the *psychological empowerment* component, all the dimensions were perceived as being empowering and within the *positive work, behavioural and attitudes* component, the respondents experienced low stress and low burnout levels, which Kanter considers an empowering milieu. Organisational structure as a concept obtained a mean score of 3.42 which is below 3.75 as indicated in Table 4.22. The organisational structure mean score was therefore considered not to be empowering. However, this is contrary to Table 4.21 which indicates that the respondents considered organisational structure to be empowering.

- **Distinguishing between non-empowered and empowered scores**

Table 4.23 shows that the respondents experienced empowerment with regard to all the dimensions of Kanter's Theory except for the low mean score on resources. The mean scores indicate that the empowered respondents had more resources than the less empowered respondents and they also experienced less burnout. The less empowered respondents felt less empowered with regard to all the dimensions of Kanter's Theory.

- **Mean scores of the empowerment dimension as per respondent group**

The mean scores of nurse managers in Table 4.26 indicate that they felt more empowered than registered nurses with regard to the structural empowerment dimensions; both groups had limited resources, with nurse managers experiencing less burnout than registered nurses.

- **Distinguishing between non-empowered and empowered scores for the two categories of respondents**

Table 4.27 indicates the differentiation in scores between non-empowered and empowered respondents. The empowered nurse managers and registered nurses felt empowered with regard to most of the dimensions with the exception of resources and low burnout, where both groups obtained low scores. The not empowered groups felt less empowered with all the dimensions of *structural empowerment*.

This concludes the summary of findings and conclusions derived from the findings. It is evident that most of the respondents were in fact empowered by most of the dimensions stipulated in Kanter's Theory.

5.7 DEVELOPMENT OF EMPOWERMENT GUIDELINES

The development of the guidelines formed phase 2 of the study. The scientific contribution of this study lies in the development of guidelines by which the empowerment of nurses can be enhanced, therefore this section will describe guidelines and how they should be formulated, after which the specific guidelines pertaining to the study will be formulated. The discussion will include a definition of

guidelines, an explanation of evidence-based management as well as evidence-based practice, the reason why guidelines should be formulated, and the process of developing guidelines.

In this study the empowerment guidelines were developed with the purpose of improving the empowerment of nurse managers and registered nurses in the eight selected public hospitals within the Ehlanzeni district of the Mpumalanga Province. The empowerment guidelines were based on the findings of the research study and the extensive literature review related to the study phenomena.

This study was based on Kanter's *Theory of Structural Empowerment* which is divided into three components. The first component is concerned with *structural empowerment,* which includes the dimensions of opportunity, information, support, resources, formal power and informal power. Component two is concerned with *psychological empowerment* which includes meaning, confidence, autonomy and impact. Component three is about *positive work behaviours and attitudes* and includes job satisfaction, commitment, low stress and low burnout as sub-components (Lucas et al 2008:965).

5.7.1 Definition of guidelines

Guidelines are directing principles which lay out suggested policy procedure or non-mandatory rule (Johnson & Stoskopf, 2013:414). Guidelines are also viewed as administrative guidelines that are promulgated by an administrative agency in order to produce or interpret the law (Johnson & Stoskopf, 2013:414). Within the health services, guidelines are standardised specifications developed through a process that uses the best scientific evidence and expert opinion for the care of the typical patient in the typical situation (Grohar-Murray & Langan 2011:184). Guidelines are effective tools for improving the quality of care (Kelly & Tazbir 2014:327).

It is important to explain two concepts in the development of guidelines, namely evidence-based management and evidence-based practice. These concepts are important in the daily functioning of managers and practitioners.

- *Evidence-based management* refers to the use of evidence such as research findings and recommendations to support management decisions (Finkelman &

Kenner 2013:492). Evidence-based management means translating principles based on best evidence into organisational practices (Luthans 2011:12). *Evidence-based management* means basing managerial decisions on the best scientific evidence; managers are expected to be more scientific in how they think and solve management problems or make decision in their daily practice (Robbins et al 2009:9).

- *Evidence-based practice* refers to the integration of the best evidence into clinical practice, which includes research, patients' values and preferences, patients' history, examination data, and clinical expertise (Finkelman & Kenner 2013:492). Evidence-based practice is a problem-solving approach to making clinical, educational, and administrative decisions that combines the best available scientific evidence with the best practical evidence. *Evidence-based practice* assists nurses by increasing their clinical knowledge and it enables them to have greater autonomy to act and thereby increases their empowerment (Finkelman & Kenner 2013:351).

According to Demendonca (2009:259), there are three common reasons for developing guidelines in the health care management environment. They are:

- To improve the quality of health care.
- To reduce the use of unnecessary, ineffective or harmful interventions.
- To facilitate the treatment of patients with the maximum chance of benefits with minimum risk of harm, and at an acceptable cost.

5.7.2 Process of developing guidelines

The following section will focus on the development of the empowerment guidelines.

5.7.2.1 Steps followed in the development of guidelines

The researcher followed logical reasoning processes in order to develop empowerment guidelines for nurse managers and registered nurses (Polit & Beck 2008:13). The research study was primarily conducted through the quantitative approach. Conclusions of this study were drawn from the views of the respondents about the empowerment of

nurses obtained from closed-ended and open-ended questions.The process of reasoning involves induction or deduction or both (Brink et al 2012 5).

- **Logical reasoning process**

According to Polit and Beck (2008:13), logical reasoning is a problem-solving method that allows researchers to use formal systems of thought. The process of reasoning involves induction or deduction or both (Brink et al 2012 5).

- **Inductive reasoning**

According to Moule and Goodman (2014:5), inductive reasoning refers to the process of making generalisations based on specific observations made out of facts (Brink et al 2012 5). Inductive reasoning assists researchers in drawing conclusions about phenomena under study (Parahoo 2014:408), in this case drawing conclusions based on the views of the respondents.

- **Deductive reasoning**

Deductive reasoning refers to the process of developing specific observations from general guidelines (Brink et al 2012:6). Deductive reasoning is also described as a process of developing specific predictions from general principles (Polit & Beck 2008:13). Quantitative research focuses on deductive reasoning. In this study the researcher drew conclusions from the experiences of the respondents through analysis of data generated from closed-ended and open-ended questions. Subsequently the study findings were used to develop guidelines and recommendations for the empowerment of nurses. The guidelines were developed in accordance with the components of Kanter's Theory of structural empowerment. These components are *structural empowerment, psychological empowerment* and p*ositive work behaviours and attitudes.*

- **Validation of the guidelines**

There are different strategies that the researcher could implement in order to validate guidelines. The instrument that is widely used for the evaluation of the applicability of

guidelines is the Appraisal of Guidelines Research and Evaluation tool (AGREE). The AGREE assessment instrument evaluates: the scope and purpose of the guidelines, stakeholder involvement, rigor of the guideline development, clarity and presentation of the guidelines, applicability of the guideline to practice, and demonstrated editorial independence of the developers (LoBiondo-Wood & Haber 2010:214). In this study the validation of guidelines was carried out by making use of the instrument adapted from the criteria and rating scale used by (Leech et al 2007:110; Swardt 2012:3), which included: validity, reliability, clarity, credibility, comprehensiveness and applicability. The experts who participated in the evaluation of the guidelines included twelve evaluators:

- Nurse managers in charge of hospitals
- Guideline experts
- A nurse educator (principal of a nursing school)
- Supervisors of nursing units (area managers)
- A health and safety nurse (registered nurse)
- A quality assurance officer (registered nurse)
- A clinical preceptor (registered nurse)
- A regulatory body (SANC) guideline expert

The researcher provided the experts with the electronic copy/hard copy of the proposed guidelines with the criteria against which the guidelines were to be evaluated. The experts were also provided with the theoretical framework of the study on Kanter's Theory of Structural Empowerment, the covering letter with information stipulated in Annexure A of the content validity instrument and information on the informed consent (Annexure D), which experts were requested to sign if they wished to participate in the evaluation of guidelines. After the receipt of the evaluated guidelines, the researcher read through the feedback from the experts and made relevant changes to the guidelines. The guidelines could further be disseminated in a nursing research journal in order to enhance the empowerment of registered nurses in their service, and in turn cultivate confident nurse leaders.

5.7.2.2 Kanter's Theory of structural empowerment as basis for guideline development

The research study is based on the conceptual framework of Kanter's Theory. The theory is divided into three components, namely *structural empowerment, psychological empowerment and positive work behaviours and attitudes.* Each component of Kanter's Theory is divided into dimensions. In this study there are two concepts which do not form component of Kanter's *Theory of Structural Empowerment*, namely empowerment and organisational structure, which the researcher felt should be included as they impact on the empowerment of employees in the workplace.

The development of guidelines is focused on the dimensions which were found to be non-empowering, and is presented in accordance with the three components of Kanter's *Theory of Structural Empowerment*.

5.7.2.2.1 Structural empowerment

The component of *structural empowerment* consists of six dimensions, namely opportunity, information, support, resources, formal power and informal power. In this component the researcher formulated a guideline on the dimension of resources which was found to be an inhibiting factor for the execution of allocated duties. No guidelines were formulated for the following dimensions: opportunity, information, support, formal and informal power, as the respondents reported that they felt empowered in these areas.

From the dimension of resources under the component of *structural empowerment*, a guideline was formulated which addresses the availability of resources in the workplace which are needed to enable nurse managers and registered nurses to perform their functions effectively. This guideline is based on the experiences reported by the respondents as indicated in box 5.1.

Box 5.1 Summary of concluding statements regarding the dimension of resources in the workplace

Respondents considered the dimension of resources as not being empowering because they felt that they were not provided with:

- Adequate personnel to enable them to meet organisational goals
- Necessary equipment to execute allocated tasks
- Sufficient supplies necessary for their jobs and patient care

Respondents indicated the following as the most important resource barriers to their performance in the organisation:

- Lack of material resources/equipment
- Shortage of nursing staff and doctors

Respondents identified the following aspects pertaining to resources which would enhance the performance of their allocated duties as:

- More competent nurses should be employed
- Medical equipment
- Computers
- Training and in-service training on basic computer skills.
- Neonatal training

- **Guideline 1: Provide adequate and sufficient resources in the workplace**

Rationale for implementing the guideline

By implementing this guideline, sufficient resources of the required nature, would provide the means for nurses to perform their allocated tasks and professional responsibilities without difficulties, thus enhancing patient care, staff satisfaction and a sense of achievement.

Recommendations for the implementing of the guideline on resources

In dealing with a shortage of resources, attention should not only be given to the acquisition and utilisation of these resources but also to the training and development of staff who have to order, motivate for, utilise and maintain the existing resources in a cost-effective manner.

In view of the following resources, management is advised to:

Human resources

- Conduct surveys twice a year to assess the nurse-patient ratio in order to determine the staffing needs of each nursing unit and present the identified needs to relevant authorities for managerial support.
- Identify employees who do not possess basic computer skills and motivate for their development by submitting their names to the skills development section for relevant training. Basic computer skills will assist in empowering nurses by enabling them to access medical and nursing expertise, develop problem-solving skills and search for information that they might need in order to improve the nursing care provided to patients.
- Encourage nursing unit managers and registered nurses to formally communicate their resource needs to managers to make them aware of the resource limitations which hamper optimal care.
- Create opportunities for growth by allowing nurses to identify their own learning needs with the assistance of their supervisors in order to facilitate professional development and personal growth of employees, thus increasing the number of competent nurses.
- Monitor the implementation of the Skills Development Act no 97 of 1998; to assist employees in acquiring new skills that are necessary for accomplishing delegated duties.

Equipment

- Provide adequate medical equipment and advise nurse managers and registered nurses on how to store and utilise the equipment correctly to prolong the working life of the equipment and promote the safety of patients.
- Monitor the acquisition and utilisation of equipment in order to be able to identify areas in which nurse managers and registered nurses need to be developed with the aim of improving their knowledge and skills in acquiring, using, controlling and condemning equipment.

Material resources

- Monitor the acquisition and utilisation of material resources in order to be able to identify areas in which nurse managers and registered nurses need to be developed with the aim of improving their knowledge and skills relevant to material resources.
- Monitor whether unit managers and registered nurses are familiar with the institutional procedure for the procurement of material resources to promote adherence to the institutional regulations.
- Establish unit/departmental committees and conduct meetings with the nurse managers, unit managers, unit nursing staff representatives quarterly to allow employees to share ideas, expertise and good practices on the acquisition and maintenance of material resources.

In-service training programme

- Develop an in-service training programme on budgeting and procurement processes, effective utilisation of equipment, facilities and supplies to empower nurse managers and registered nurses.
- Conduct in-service training in basic computer skills to enable nurse managers and registered nurses to access information that is necessary for accomplishing delegated responsibilities.

Collaboration with Provincial department of Health

- Collaborate with the Mpumalanga Provincial Department of Health through meetings in order to present the views of respondents with regard to the availability of resources in the eight public hospitals Mpumalanga Province.

5.7.2.2.2 Psychological empowerment

The following section pertains to the second component of Kanter's *Theory of Structural Empowerment.* The dimensions of this component include meaning, confidence, autonomy and impact. In this study the dimension of confidence was replaced with competence as discussed in Chapter 2 in section 2.3.2 (*psychological empowerment*). According to the findings of the study, the respondents felt empowered regarding three dimensions of *psychological empowerment* but felt less empowered regarding the dimension of competence, in particular having to perform tasks that are not covered by their scope of practice. Based on the results the formulated guideline focused on the dimension of competence.

Based on the dimension of competence in the component of *psychological empowerment,* a guideline was formulated which addresses the perceived lack of adherence to the scope of practice in nursing practice. This aims at empowering nurse managers and registered nurses on the allocation of tasks according to the knowledge, skills and abilities of the nurse within the ambit of regulation relating to the Scope of Practice of registered nurses and midwives R2598 of 2005.

Box 5.2 Summary of concluding statement regarding the dimension of competence in the workplace

Respondents considered the dimension of competence as not being empowering because they were:

- Required to perform tasks that were not covered by their scope of practice.

- **Guideline 1: Allocate tasks to registered nurses according to the scope of practice based on the knowledge, skills and abilities of each nurse**

Rationale for implementation of the guideline

It is envisaged that the allocation of tasks according to the scope of practice of registered nurses will empower nurse managers and registered nurses if tasks are allocated based on the knowledge, skill and abilities of a nurse and will thus decrease tension and promote psychological empowerment through autonomous decision-making.

Recommendations for the implementation of the guideline for the dimension of competence

Management is advised to:

- Adhere to the scope of practice of the different categories of nurses when allocating tasks to subordinates; this will allow nurses to be confident in utilising their relevant knowledge, skills and expertise when performing allocated responsibilities.
- Encourage nursing unit/ward managers to give unambiguous instructions and a precise description of tasks allocated to enable a clear understanding by the subordinate of what is required of him/her; for example by giving guidance, coaching, and hands-on assistance where nurses are faced with challenging tasks pertaining to patient care.
- Create opportunities for nurses to network with other nurses in the organisation and outside the organisation to engender an atmosphere for sharing of ideas and information in order to improve nurses' competence.
- Draw and implement developmental plans to address nurses' performance deficiencies based on the identified learning and or developmental needs in order to enhance proficiency and the empowerment of nurses.

5.7.2.2.3 Positive work behaviours and attitudes

The component of *positive work behaviours and attitudes* is the third and last of Kanter's *Theory of Structural Empowerment.* This component comprises of job satisfaction, commitment, low stress and low burnout.

5.7.2.2.3.1 The dimension of job satisfaction

The guideline on the dimension of job satisfaction addresses the unfair salaries as perceived by employees and the creation of promotional and career planning opportunities for nurses which might improve job satisfaction of employees in the workplace.

Box 5.3 Summary of concluding statements regarding fair salaries in the workplace

Respondents' views on unfair salaries/remuneration in relation to the work they do.

Respondents perceived salaries/remuneration as not being empowering because:

- They did not receive fair salaries

- **Guideline 1: Implement the Public Service Act 1994 (proclamation No 103 of 1994) section 37 (1) to establish a foundation for the remuneration of officers and employees.**

Rationale for implementation of the guideline

By implementing the Public Service Act 1994, (proclamation No 103 of 1994), section 37 (1), a fair and comprehensive remuneration is provided to employees.

Recommendations for implementation of the guideline for the dimension of job satisfaction

Management is advised to:

- Monitor whether performance appraisals are conducted according to set standards to ensure that employees who are ready for promotion are identified and promoted if posts are available; this will assist in addressing the remuneration packages of employees where it is deserved.
- Nominate employees whose performance is above the set standards, who qualify for incentive bonuses and pay progression and present them to the performance management development moderation committee (PMDMC**)** in order to be able upgrade their salaries.

5.7.2.2.3.2 Guideline for the dimensions of low stress and low burnout

This guideline addresses the high work load nurses experience which leads to increased levels of stress and burnout, and it aims at empowering nurse managers and registered nurses on how to create workplace environments that lessen stress and burnout levels in employees.

Box 5.4 Summary of concluding statements regarding the workload in the workplace

Due to the workload the respondents carry, they considered the workplace not to be empowering because they:

- Complained of tiredness
- Found it difficult to take tea and lunch breaks
- Felt overloaded with work due to shortage of staff
- Were unable to catch up with the work they were expected to do.

- **Guideline 2: Manage the workload constructively in the workplace**

Rationale for implementation of the guideline

Implementation of this guideline will empower nurse managers and registered nurses to create workplace environments that lessen stress levels in their ward/units.

Recommendations for implementation of the guideline for the dimension of low stress and low burnout

Management is advised to:

- Increase their own observational skills to detect whether tasks are delegated according to the educational level and capabilities of the employee.
- Provide adequate human resources by motivating for the filling of vacant posts if available to enable nurses to accomplish delegated tasks in a fair and reasonable manner.
- Empower nursing ward/unit managers and subordinates to plan and schedule their work activities by means of sound time management in order to be able to accomplish the set goals; this can be achieved by in-service training which will assist employees in lowering their stress levels.
- Monitor the implementation of the Basic Conditions of Employment Act (No 75 of 1997) which addresses regulation of working time, overtime, mealtime and teatime and daily and weekly rest periods to limit work overload that could lead to physical consequences of stress and burnout.
- Provide information to employees about the availability of employee assistance programmes. Employees who show stress-related symptoms are to be referred for professional counseling in order to enable them to deal with their stressful challenges.
- Provide managerial support by means of open communication and genuine commitment for nurses who have a need to discuss difficulties at work and express experiences of work overload.
- Develop an employee retention strategy whereby job satisfaction is enhanced and staff turnover is reduced to minimise the shortage of nurses.

5.8 VALIDATION OF THE GUIDELINES

To determine the feasibility and accessibility of the developed guidelines, the researcher set out to have the guidelines assessed by nursing practitioners in different fields of nursing. The researcher selected experts and requested them to participate in the evaluation of the guidelines. The experts were provided with a copy of the proposed guidelines, a copy of the theoretical framework used as the foundation of the study and

a covering letter explaining why the guidelines were developed, and an explanation of how the validation should be conducted (Annexure F). The experts were also given a validation form with the rating scale explaining how the instrument should be used when evaluating the guidelines. The researcher selected twelve (12) experts and requested them to validate the empowerment guidelines.

The outcome of the validation process is indicated in (Annexure F). The experts were two nurse managers, four nurse educators, one clinical preceptor, 3 registered nurses and two supervisors (area managers). The experts were requested to validate the guidelines according to the rating scale and criteria: validity, reliability, clarity, credibility, comprehensiveness and applicability. The experts were also asked to assess and evaluate the guidelines on their own to avoid the possibility of influencing each other. One evaluator (nurse manager) did not give feedback on the evaluation of the guidelines despite being reminded by the researcher several times. Table 5.1 indicated the attributes of the experts. The attributes included: position, employer, expertise and academic qualifications.

The evaluators' comments on the empowerment guidelines:

***Validity*:** The evaluators indicated that the guidelines were derived from the findings and further indicated that guidelines were valid because they were based on evidence.

Reliability: The guidelines were considered to be reliable as the emphasis was on the chosen theoretical framework of Kanter's *Theory of Structural Empowerment* for their development. Other comments indicated that any professional could use the guidelines, and they could easily be implemented by any nurse.

***Clarity*:** The evaluators mentioned that the guidelines were clear.

***Credibility*:** The guidelines were reported to be containing what directly affected registered nurses in the Mpumalanga Province

***Comprehensiveness*:** The evaluators indicated that the guidelines emphasised the specific dimensions of Kanter's *Theory of Structural Empowerment*, and all three of the aspects (components) of the theory were addressed.

Applicability: The evaluators reported that the population to which recommendations (statements) applied was clearly addressed in all the guidelines.

5.9 RECOMMENDATION FOR FURTHER RESEARCH

Further research is recommended regarding empowerment in the nursing profession. This research could be repeated in other districts of Mpumalanga Province and in other provinces as well. Further investigation could be carried out within the three districts of the Mpumalanga Province to assess whether tasks are allocated according the knowledge, skills and abilities of nurses in nursing practice considering their scope of practice. A qualitative research study about the use of power in health care organisations might set new perspectives on this topic. Further research could also be conducted to assess the impact of the empowerment guidelines after they have been implemented by the different hospitals in order to assess whether the guidelines contributed positively to the empowerment of registered nurses.

5.10 LIMITATION OF THE STUDY

The researcher identified the following weaknesses in the study.

- ***Generalisation of the research findings***: The study was only conducted in eight (8) hospitals within the Ehlanzeni district of the Mpumalanga Province. The site was randomly selected from the three districts of the Mpumalanga Province. The results of the study would not be generalised to the other two districts within the Mpumalanga Province.

- ***The low response rate*****:** The research study included nurse managers and registered nurses. The respondents were found to be very busy during the distribution of questionnaires; however the researcher did get the time to explain the purpose of the study, and noted that participation was voluntary and that respondents could withdraw their participation at any given time. For some of the respondents it was not possible to complete the questionnaire when the researcher was still in the hospitals. Seeing that the return rate did not increase, the researcher on several occasions communicated with nurse ward/unit

managers through phone calls to remind the respondents to complete the questionnaires but to no avail. The researcher had to extend the return date by two months with the aim of giving the respondents time to participate in the study, but the return rate did not increase. The low return rate contributed negatively to the data collection process, data analysis, and ultimately to the outcome of the research study because the researcher could not obtain the views of all the respondents on the empowerment of registered nurses.

Another limitation that might have led to the low return rate, is that the researcher conducted a pre-testing of the data collection instrument instead of a pilot study because a pilot could have assisted the researcher to identify the problems and could have helped the researcher to plan for the challenges that the researcher experienced during the period of the data collection.

- ***Question formulation in a questionnaire***: question 6.6.1 in section C – 'My supervisor organises sponsors for my seminars that are related to my job'. The researcher included this question in order to find out whether supervisors are able to identify the developmental needs for professional networking that is relevant to the job of employees, even though it is not their responsibility to organise sponsors but it is the human resources development. This question might not have been formulated clear.

- ***Question formulation in a questionnaire***: In retrospect, question 8.1.3 in section E – 'My work climate is not challenging' - might not have been clear. The question formulation with a 'not' always creates difficulty in comprehension for the respondents. The respondents might have experienced some difficulty in choosing the correct response. And was 'work climate' the appropriate aspect to assess, and did 'challenging' refer to the difficulties or growth opportunities within the work environment?

- ***The high number of neutral responses*:** The results showed that the respondents often opted for the neutral response, even in cases where it was a straightforward question. This detracted from getting strong positive and or negative results, thus negatively affecting the outcome of the results. The high

level of neutral responses might suggest that the respondents did not want to indicate their undesirable opinion.

- ***The dimension of confidence*:** this dimension in Chapter 2, Table 2.1 is cited as confidence under the *psychological empowerment* component, but in the questionnaire it was replaced with the dimension of competence based on several similar research studies, which is not in line with Kanter's *Theory of Structural Empowerment.* The dimension of confidence was replaced with the dimension of competence based on several similar research studies as discussed in Chapter 2 in section 2.3.2 (*psychological empowerment*).

5.11 CONCLUSION

In the beginning of this chapter an overview and brief summary was given about the study thus far. In this chapter, the findings and recommendations in the form of guidelines were provided. In this research, the empowerment of registered nurses in the public hospitals of one district in the Mpumalanga Province was studied. The study was based on Kanter's *Theory of Structural Empowerment*. Most of the dimensions were found to be empowering. With regard to the component of *structural empowerment*: nurse managers considered information more empowering than registered nurses; formal power was found to be more empowering for both groups (nurse managers and registered nurses); informal power was more empowering for registered nurses than for nurse managers.

In the component of *psychological empowerment* the dimension of meaning was found to be more empowering for nurse managers than for registered nurses; the dimension of impact was more empowering for registered nurses than for nurse managers.

Regarding the third component of *positive work behaviours and attitudes,* the dimension of experiencing low stress was considered as empowering. As for the dimension of burnout, registered nurses felt slightly more empowered by experiencing low levels of stress than did nurse managers. The empowerment guidelines were developed for dimensions which were found to be non-empowering to assist nurse managers and registered nurses in creating workplace environments that could enhance the empowerment of registered nurses.

The findings indicate that most of the respondents were in fact empowered by most of the dimensions contained in Kanter's Theory, for which credit should be given to the relevant management teams of selected hospitals. It is therefore hoped that the findings, empowerment guidelines and the recommendations of this study will have a positive impact on the further empowerment of registered nurses in the selected hospitals within the one district (Ehlanzeni district) of the Mpumalanga Province.

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ANNEXURES

ANNEXURE A: QUESTIONNAIRE

TO:

Nurse managers and registered nurses working in selected hospitals within the Ehlanzeni District of the Mpumalanga Province.

SUBJECT: Completion of a questionnaire in view of a doctoral study (D Litt et Phil) at the University of South Africa in the Department of Health Studies

RESEARCH TOPIC: GUIDELINES FOR THE EMPOWERMENT OF PROFESSIONAL NURSES IN THE PUBLIC HOSPITALS OF ONE DISTRICT IN THE MPUMALANGA PROVINCE

The anticipated value of the research will depend on your responses to the questions posed in the questionnaire. Your answers will enable the researcher to draw certain conclusions and make recommendations. It is hoped that the findings of the study will be useful in creating more opportunities for empowerment.

Please Note: Read all the questions carefully before attempting to answer the questions. Complete the questionnaire according to your personal knowledge concerning the various issues raised. Give honest answers reflecting your point of view, no matter whether it is positive or negative. The following has relevance:

- All the information will be treated in confidence and will serve no purpose other than to gain information on the topic.
- Do not give or sign your name **anywhere** on the questionnaire.
- Thank you for your participation in this research.

Researcher: Miss Constance Siphiwe Peggy Lephoko (Lecturer)
Mpumalanga College of Nursing
Private Bag X1005
KABOKWENI
1245

COMPOSITION OF QUESTIONNAIRE

This questionnaire consists of eight (8) sections A, B, C, D, E, F and G.

SECTION A:

Items relating to personal particulars of the respondents.

SECTION B:

Questions relating to empowerment.

SECTION C:

Questions relating to structural empowerment.

SECTION D:

Questions relating to psychological empowerment.

SECTION E:

Questions relating to work behaviours and attitudes.

SECTION F:

Questions relating to organisational climate.

SECTION G:

Open-ended questions on the empowerment of registered nurses.

Thank you for your cooperation

……

Ms CSP LEPHOKO

1 2 3

EMPOWERMENT QUESTIONNAIRE FOR NURSE MANAGERS AND REGISTERED NURSES

SECTION A: PERSONAL INFORMATION

To answer, please tick the response in the appropriate box.

Question 1**:** What is your current position (rank) within the hospital?

Group	**Position/Rank**	**Answer**
Group A	Nurse manager	1
Group B	Registered nurse	2

4

Question 2: How long have you been functioning in your current position as a nurse manager or registered nurse?

Years	**Response**
1-5	1
6-10	2
11-15	3
16-20	4
21 and more	5

5

Question 3: Indicate your gender.

Gender	**Response**
Male	1
Female	2

6

Question 4: In which age category do you fall?

Age	Response
21-25	1
26-30	2
31-35	3
36-40	4
41-45	5
46-50	6
51-55	7
56-60 and more	8

7

Questions in the following sections are arranged according to specific subheadings. Please indicate your level of agreement with the statements in each section by using the following scale:

1 = Strongly disagree (SD)

2 = Disagree (D)

3 = Neutral (N)

4 = Agree (A)

5 = Strongly agree (SA)

	ITEMS	1 SD	2 D	3 N	4 A	5 SA	
5.	**SECTION B: Empowerment**						
5.1	I participate in policy formulation.						8
5.2	I am encouraged to make decisions that affect my unit.						9
5.3	My supervisor practices participative management when making decisions.						10
5.4	I am permitted to learn from making mistakes.						11
5.5	I am allowed to apply all my competencies and skills in problem-solving actions in my work environment.						12
6.	**SECTION C: Structural empowerment**						
6.1	**C1: Opportunity**						
6.1.1	My supervisor allows me to attend job-related seminars to improve my skills.						13
6.1.2	My supervisor coaches me when I am uncertain about a certain task or function.						14
6.1.3	My supervisor delegates challenging tasks to me.						15
6.1.4	My supervisor considers my requests when compiling the off duties.						16
6.1.5	My supervisor gives me the opportunity to participate in management decisions in the area of my responsibilities.						17
6.2	**C2: Information**						
6.2.1	My supervisor allows me to give input in issues that relate to my tasks/responsibilities.						18
6.2.2	My supervisor shares his/her experience and expertise with me.						19
6.2.3	My job description is relevant to the job I am expected to perform.						20
6.2.4	I am oriented with regard to new policies and organisational procedures.						21
6.2.5	My supervisor regularly gives me feedback regarding my work.						22

6.2.6	My supervisor provides me with information that I need to carry out my duties.							23
6.3	**C3: Support**							
6.3.1	My supervisor allows me to utilise my talents, such as analytical skills, to solve problems in my unit.							24
6.3.2	My supervisor listens to my concerns.							25
6.3.3	My supervisor considers my suggestions.							26
6.3.4	My supervisor gives clear direction when delegating responsibility.							27
6.3.5	Recognition is given for work well done.							28
6.4	**C4: Resources**							
6.4.1	My unit is provided with sufficient supplies on an ongoing basis, to perform the tasks and patient care activities.							29
6.4.2	My employer provides the equipment necessary for me to execute my allocated tasks.							30

	ITEMS	**1 SD**	**2 D**	**3 N**	**4 A**	**5 SA**		
6.4.3	My supervisor requests my input when compiling the operational budget.							31
6.4.4	I am provided with adequate personnel to enable me to meet the organisational goals.							32
6.4.5	In my unit we exceed the allocated time for meetings.							33
6.5	**C5: Formal power**							
6.5.1	I am permitted to make decisions within the scope of my responsibility.							34
6.5.2	I am allowed to use my discretion in matters relating to my job.							35
6.5.3	Appropriate in-service education programmes are available, allowing me to grow professionally.							36
6.5.4	My supervisor recognises my professional developmental needs.							37
6.5.5	I am made aware of the hospital's goals and objectives.							38
6.6	**C6: Informal power**							
6.6.1	My supervisor organises sponsors for seminars that are related to the job.							39
6.6.2	My colleagues and I share knowledge to empower one another.							40
6.6.3	I am allowed to establish professional networks with other registered nurses to share ideas about patient care.							41
6.6.4	My supervisor respects me for the expertise I exhibit in my work.							42
6.6.5	My supervisor considers the contributions of subordinates.							43
7.	**SECTION D: Psychological empowerment**							
7.1	**D1: Meaning**							
7.1.1	I am allowed to set goals for my ward/unit.							44
7.1.2	My supervisor appreciates and supports the goals I establish.							45

7.1.3	I am allowed to express my beliefs and values in my unit.							46
7.1.4	I regard myself as competent in the manner I execute my duties.							47
7.1.5	I am capable of identifying conditions that foster powerlessness.							48
7.2	**D2: Competence**							
7.2.1	My supervisor considers my capabilities when allocating tasks.							49
7.2.2	My supervisor involves me in the planning of my developmental activities after performance appraisal feedback.							50
7.2.3	My supervisor acknowledges that I am competent to perform delegated tasks.							51
7.2.4	When delegating responsibilities, my supervisor gives me authority to make the necessary decisions.							52

	ITEMS	**1 SD**	**2 D**	**3 N**	**4 A**	**5 SA**		
7.2.5	I am required to perform tasks that are not covered by my scope of practice.							53
7.2.6	I am assertive in speaking out for my own rights in terms of a fair work environment.							54
7.3	**D3: Autonomy/self-determination**							
7.3.1	My supervisor gives me autonomy to determine the outcomes in my ward/unit.							55
7.3.2	My supervisor allows me to control work conducted in my unit.							56
7.3.3	Autonomy is actively cultivated among nurses in the organisation.							57
7.3.4	My supervisor encourages me to perform at my best.							58
7.3.5	I have discretional power to allocate responsibilities to my subordinates.							59
7.4	**D4: Impact**							
7.4.1	My supervisor listens to my ideas.							60
7.4.2	My supervisor provides me with feedback which enables me to grow.							61
7.4.3	My supervisor acknowledges my contribution to my patients' wellbeing.							62
7.4.4	My supervisor recognises my ability to influence job outcomes.							63
7.4.5	My supervisor allows me to interact with colleagues to improve nursing practice.							64
8.	**SECTION E: Work behaviours and attitudes**							
8.1	**E1: Job satisfaction**							
8.1.1	I receive a fair salary for the work that I do.							65
8.1.2	The work climate in the ward where I am working is free from harassment.							66
8.1.3	My work climate is not challenging.							67
8.1.4	My supervisor is approachable.							68
8.1.5	I am expected to regularly perform non-nursing tasks.							69

8.2	**E2: Commitment**							
8.2.1	My supervisor ensures that relevant in-service training is conducted.							70
8.2.2	My supervisor ensures effective utilisation of resources.							71
8.2.3	My supervisor is committed to effective patient care.							72
8.2.4	My supervisor assists in preparing for promotions.							73
8.2.5	My supervisor's leadership style engenders commitment among nurses.							74
8.3	**E3: Low stress**							
8.3.1	I am treated with respect by my seniors.							75
8.3.2	The nurses in my ward/unit are overloaded with work.							76
8.3.3	My organisation promotes lifelong learning.							77
8.3.4	My organisation has a career development plan for every employee.							78

	ITEMS	**1 SD**	**2 D**	**3 N**	**4 A**	**5 SA**		
8.3.5	Allocation of tasks is according to the individual's abilities.							79
8.3.6	My supervisor handles conflict within the ward/unit in a timely and effective manner.							80
8.4	**E4: Low burnout**							
8.4.1	My supervisor is judgmental about everything I do.							81
8.4.2	I do not have enough time to effectively attend to my patients' needs.							82
8.4.3	I am required to work overtime on a regular basis.							83
8.4.4	My work environment is noisy.							84
8.4.5	I am not given authority to control my job-related tasks but am held accountable.							85
8.4.6	The workload and tempo are so high that I never seem to catch up with everything I need to do.							86
9.	**SECTION F: Organisational structure**							
9.1	Nurses in my unit are given authority to act according to their post levels.							87
9.2	My supervisor adheres to an open door policy.							88
9.3	I have more than 15 subordinates reporting to me.							89
9.4	I have the authority to institute disciplinary measures against my subordinates.							90
9.5	I have the right to initiate a grievance process when aggrieved.							91

SECTION G: OPEN-ENDED QUESTIONS

PLEASE GIVE PRECISE ANSWERS TO THE FOLLOWING OPEN-ENDED QUESTIONS. PLEASE GIVE EXAMPLES WHERE POSSIBLE.

1. What challenges / problems do you experience regarding your decision-making role in your organisation?

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2. What kind of assistance do you receive from your supervisor regarding delegated tasks?

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3. Indicate the most important barriers to your performance in the organisation.

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4. Indicate any resources which might enhance the performance of your allocated duties.

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5. How do you assist your supervisor to make job-related decisions?

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6. Why do you feel that the nurses are overloaded/not overloaded with work in your ward?

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7. How do you exert authority to control your job-related duties?

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Thank you for your cooperation!

.....

CSP LEPHOKO (Ms)

ANNEXURE B1: REQUEST TO CONDUCT A RESEARCH STUDY IN THE MPUMALANGA PROVINCE WITHIN THE EHLANZENI DISTRICT

Mpumalanga College of Nursing
Private Bag X1005
KABOKWENI
1245
26.06.2012

The Department of Health Ethics Research Committee
Mpumalanga Provincial Office
Private Bag X11285
1200

Dear Sir/Madam

MPUMALANGA PROVINCE DEPARTMENT OF HEALTH RESEARCH ETHICS COMMITTEE

I, Constance S P Lephoko, am a D Litt et Phil student at UNISA in the Department of Health Studies. I am conducting a research study on empowerment of nurse managers and registered nurses in the Mpumalanga Province within the Ehlanzeni District.

The goal of the study is to determine what empowerment encompasses, establish the reasons for the lack of empowerment in nurse managers and registered nurses, and to make recommendations that managers can implement to enhance the empowerment of nurses in their services, in order to cultivate confident assertive nurse leaders.

I therefore request that you grant me permission to conduct the research study in the Mpumalanga Province within the Ehlanzeni District

The topic for the research study is:

GUIDELINES FOR THE EMPOWERMENT OF PROFESSIONAL NURSES IN THE PUBLIC HOSPITALS OF ONE DISTRICT IN THE MPUMALANGA PROVINCE

The research study will use a questionnaire, which will be distributed to nurse managers and registered nurses.

The researcher will submit the letter of request to the institutions, in order to conduct the study after the Ethical Clearance Committee of Higher Degree in the Department of Health Studies at UNISA and the Mpumalanga Province Research Ethics Committee, have granted the permission to conduct the study.

I thank you for your cooperation.

Yours faithfully

.....

CSP LEPHOKO

ANNEXURE B2 – B10 REQUEST TO CONDUCT A RESEARCH STUDY AT THE SELECTED HOSPITALS

For the purpose of anonymity and confidentiality, the request letters have not been included in this annexure but are available on special request.

ANNEXURE C1: UNISA ETHICAL CLEARANCE CERTIFICATE DEPARTMENT OF HEALTH STUDIES

UNISA university of south africa

UNIVERSITY OF SOUTH AFRICA
Health Studies Higher Degrees Committee
College of Human Sciences
ETHICAL CLEARANCE CERTIFICATE

HSHDC/117/2012

Date: 12 December 2012 Student No: 0462-360-6

Project Title: Empowerment of professional nurses

Researcher: Constance Siphiwe Peggy Lephoko

Degree: D Litt et Phil Code: DIS890B

Supervisor: Prof MC Bezuidenhout
Qualification: D Litt et Phil
Joint Supervisor: Prof JH Roos

DECISION OF COMMITTEE

Approved [√] **Conditionally Approved** [ ]

Prof L Roets
CHAIRPERSON: HEALTH STUDIES HIGHER DEGREES COMMITTEE

Dr MM Moleki
ACTING ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

ANNEXURE C2: LETTER OF APPROVAL TO CONDUCT A STUDY FROM THE MPUMALANGA PROVINCIAL DEPARTMENT OF HEATH ETHICS RESEARCH COMMITTEE

MPUMALANGA PROVINCIAL GOVERNMENT

Building No.3
No. 7 Government Boulevard
Riverside Park Extension 2
Nelspruit
1200
Republic of South Africa

Private Bag X 11285
Nelspruit, 1200
Tel: 013 766 3429
int: +27 13 766 3429
Fax: 013 766 3458
int: +27 13 766 3458

Department of Health

Litiko Letemphilo | Umnyango WezaMaphilo | Departement van Gesondheid

Enquiries: Themba Mulungo (013) 766 3511

04 February 2013

Ms. Constance Siphiwe Peggy Lephoko
Mpumalanga College of Nursing
Private Bag X 1005
KABOKWENI
1245

Dear Ms. Constance Siphiwe Peggy Lephoko

APPLICATION FOR RESEARCH & ETHICS APPROVAL: EMPOWERMENT OF PROFESSIONAL NURSES

The Provincial Research and Ethics Committee has approved your research proposal in the latest format that you sent.

Kindly ensure that you provide us with the soft and hard copies of the report once your research project has been completed.

Kind regards

Mr. Molefe Machaba
Research and Epidemiology

04/02/2013
Date

We care Do you? Siyanakekela

MPUMALANGA
A Pioneering Spirit

ANNEXURE C3 – C10: LETTERS OF APPROVAL TO CONDUCT A STUDY FROM THE EIGHT SELECTED HOSPITALS

For the purpose of anonymity and confidentiality, the permission letters have not been included in this annexure but are available on special request.

ANNEXURE D: INFORMED CONSENT FORM

RESEARCH TOPIC: GUIDELINES FOR THE EMPOWERMENT OF PROFESSIONAL NURSES IN THE PUBLIC HOSPITALS OF ONE DISTRICT IN THE MPUMALANGA PROVINCE

Dear respondent

I, Constance S P Lephoko, am a Doctoral (D Litt et Phil) student at UNISA in the Department of Health Studies. I am conducting a research study on the empowerment of nurse managers and registered nurses in the Mpumalanga Province within the Ehlanzeni District.

The purpose of the study is to determine what empowerment encompasses and to establish the reasons for the perceived lack of empowerment of registered nurses. Furthermore, to develop empowerment guidelines which managers can apply in order to enhance the empowerment of registered nurses in their service, and in turn cultivate confident nurse leaders.

You are hereby kindly requested to participate in this study by completing a questionnaire on the topic. This will take approximately 30 minutes of your time. Your anonymity will be ensured as your name and the name of your hospital will not be required on the questionnaire.

I ..... agree to participate in the validation of empowerment guidelines.

I understand:

- The study objectives.
- That the participation is voluntary.
- That I can withdraw from the study at any time without penalty.
- That no monetary benefits nor incentive will be provided for participating

I freely and voluntarily give my consent to participate in the validation of the empowerment guidelines.

_____	_____	_____
SIGNATURE	**PRINT NAME**	**DATE**

_____	_____
RESEARCHER'S SIGNATURE	**DATE**

ANNEXURE E: CONTENT VALIDITY INDEX

1. INTRODUCTION

The purpose of this section is to calculate the Content Validity Index (CVI) of the measurement instrument. Content Validity Index refers to the degree to which an instrument is content valid, based on the aggregated ratings of a panel of experts (Polit & Beck 2012:723). The CVI refers to a calculation that gives a researcher more evidence to be confident that the instrument truly reflects the concept or constructs under study (LoBiondo-Wood Haber 2010:576). In performing a CVI the researcher is expected to give the data collection instrument to a number of experts for them to rate the content relevance of each item in the instrument using a 4- point rating scale, ranging from 1 which is irrelevant to 4 which is highly relevant, ratings of 3 and 4 are thus considered relevant (Lynn 1998 in Grove et al 2013:395). In calculating scores, the CVI for each item is 'the proportion of expert's who rate an item as 3 or 4 on a 4-point scale, divided by the number of experts, for example, if 4 out of 6 experts rated an item as relevant (3 or 4), the CVI would be 4/6 = 0.67 (Lynn in Grove et al 2013:396) for the CVI. In this study the newly developed data collection instrument was given to five experts in order for them to assess whether the individual items are relevant and appropriate in terms of the construct being measured (Polit & Beck 2012:337).

2. BACKGROUND FOR EXPERTS

Empowerment is a process of unleashing the power in people – their knowledge, experience, and motivation, thus focussing their power to achieve positive outcomes for the organisation.

Based on the literature and Kanter's *Theory of Structural Empowerment,* a data collection instrument was developed by the researcher to measure different dimensions and constructs of empowerment. The questionnaire was divided into the following seven sections (A-G) and a 5-point Likert scale enabled the respondents to provide their views.

Section A : Contains items relating to biographic information of the respondent.
For sections B to F the respondents were required to use a five point Likert scale.

Section B : Questions relating to empowerment

Section C : Questions relating to structural empowerment

Section D : Questions relating to psychological empowerment

Section E : Questions relating to work behaviours and attitudes

Section F : Questions relating to organisational structure

Section G : Open-ended questions on aspects of empowerment listed below.

1. What challenges/problems do you experience regarding your decision-making role in your organisation?
2. What kind of assistance do you receive from your supervisor regarding delegated tasks?
3. Indicate the most important barriers to your performance in the organisation.
4. Indicate any resources which might enhance the performance of your allocated duties.
5. How do you assist your supervisor to make job related decisions?
6. Why do you feel that the nurses are overloaded/not overloaded with work in your ward?
7. How do you exert authority to control your job related duties?

3. CVI RATING

The items of the questionnaire are contained in the table below.

Please read each item and score it for its relevance to the concept noted below the 'Section' heading in relation to the empowerment of registered nurses and nurse managers. for example, Section B applies to the concept of 'empowerment' and section C to 'opportunity'. Please use the following rating scale:

Relevance Rating Scale

1. = Not relevant (NR)
2. = Somewhat relevant (SR)
3. = Quite relevant (QR)
4. = Highly relevant (HR)

4. CALCULATING THE CVI

On completion of the rating by the experts, the same table was used to capture their responses and calculate the CVI for each item, which is represented in the last column.

ITEMS		Expert 1 Nurse manager	Expert 2 Nurse manager	Expert 3 Nurse manager	Expert 4 Nurse educator	Expert 5 Registered nurse	Scores of experts	CVI
5	**SECTION B: Empowerment**							
5.1	I participate in policy formulation	1	4	4	4	4	4/5	0.80
5.2	I am encouraged to make decisions that affect my unit	3	4	4	4	4	5/5	1.0
5.3	My supervisor practices participative management when making decisions	3	4	3	4	4	5/5	1.0
5.4	I am permitted to learn from making mistakes	3	4	4	4	4	5/5	1.0
5.5	I am allowed to apply all my competencies and skills in problem-solving actions in my work environment	4	3	4	4	4	5/5	1.0
6	**SECTION C: Structural empowerment**							
6.1	**C 1: Opportunity**							
6.1.1	My supervisor allows me to attend job related seminars to improve my skills	3	4	4	4	4	5/5	1.0
6.1.2	My supervisor coaches me when I am uncertain about a certain task or function	2	4	4	4	4	4/5	0.80

6.1.3	My supervisor delegates challenging tasks to me	3	3	4	4	4	5/5	1.0
6.1.4	My supervisor considers my requests when compiling the off duties	4	4	3	4	4	5/5	1.0
6.1.5	My supervisor gives me the opportunity to participate in management decisions in the area of my responsibilities	3	4	4	4	4	5/5	1.0
6.2	C 2: Information							
6.2.1	My supervisor allows me to give input in issues that relate to my tasks/responsibilities	4	4	4	4	4	5/5	1.0
6.2.2	My supervisor shares his/her experience and expertise with me	1	4	4	4	4	4/5	0.80
6.2.3	My job description is relevant to the job I am expected to perform	4	3	4	4	4	5/5	1.0
6.2.4	I am oriented with regard to new policies and organisational procedures	4	4	4	4	1	4/5	0.80
6.2.5	My supervisor regularly gives me feedback regarding my work	4	4	4	4	4	5/5	1.0
6.2.6	My supervisor provides me with	4	4	3	4	4	5/5	1.0

	information that I need to carry out my duties							
6.3	**C 3: Support**							
6.3.1	My supervisor allows me to utilise my talents such as analytical skills to solve problems in my unit	4	4	3	4	4	5/5	1.0
6.3.2	My supervisor listens to my concerns	3	4	4	4	4	5/5	1.0
6.3.3	My supervisor considers my suggestions	2	3	4	4	4	4/5	0.80
6.3.4	My supervisor gives clear direction when delegating responsibility	4	4	3	4	4	5/5	1.0
6.3.5	Recognition is given for work well done	3	4	4	4	4	5/5	1.0
6.4	**C 4: Resources**							
6.4.1	My unit is provided with sufficient supplies on an on-going basis to perform the tasks and patient care activities	2	4	2	4	4	3/5	0.60
6.4.2	My employer provides the equipment necessary for me to execute my allocated tasks	2	4	3	4	4	4/5	0.80
6.4.3	My supervisor requests my input when compiling the	2	3	4	4	4	4/5	0.80

	operational budget							
6.4.4	I am provided with adequate personnel to enable me to meet the organisational goals.	2	4	1	4	4	3/5	0.60
6.4.5	In my unit we exceed the allocated time for meetings	1	4	1	4	3	3/5	0.60
6.5	**C 5: Formal power**							
6.5.1	I am permitted to make decisions within the scope of my responsibility	3	4	3	4	4	5/5	1.0
6.5.2	I am allowed to use my discretion in matters relating to my job	3	3	4	4	4	5/5	1.0
6.5.3	Appropriate in-service education programmes are available allowing me to grow professionally	3	4	4	4	4	5/5	1.0
6.5.4	My supervisor recognises my professional developmental needs	3	3	4	4	4	5/5	1.0
6.5.5	I am made aware of the hospital's goals and objectives	3	4	4	4	4	5/5	1.0
6.6	**C 6: Informal power**							
6.6.1	My supervisor organises sponsors for seminars that are related to the job	1	4	3	4	4	4/5	0.80
6.6.2	My colleagues and I share knowledge to empower one another	3	4	4	4	4	5/5	1.0

6.6.3	I am allowed to establish professional networks with other registered nurses to share ideas about patient care	3	4	4	4	4	5/5	1.0
6.6.4	My supervisor respects me for the expertise I exhibit in my work	3	4	4	4	4	5/5	1.0
6.6.5	My supervisor considers the contributions of subordinates.	3	4	4	4	3	5/5	1.0
7	***SECTION D: Psychological empowerment***							
7.1	**D 1: Meaning**							
7.1.1	I am allowed to set goals for my ward/unit	3	4	4	4	4	5/5	1.0
7.1.2	My supervisor appreciates and supports the goals I establish	3	4	4	4	4	5/5	1.0
7.1.3	I am allowed to express my beliefs and values in my unit	3	4	1	4	4	4/5	0.80
7.1.4	I regard myself as competent in the manner I execute my duties.	3	1	4	4	4	4/5	0.80
7.1.5	I am capable of identifying conditions that foster powerlessness.	3	4	4	4	4	5/5	1.0
7.2	**D 2: Confidence**							
7.2.1	My supervisor considers my capabilities when allocating tasks	3	4	4	4	4	5/5	1.0

7.2.2	My supervisor involves me in the planning of my developmental activities after performance appraisal feedback	3	4	4	4	4	5/5	1.0
7.2.3	My supervisor acknowledges that I am competent to perform delegated tasks	4	3	4	4	4	5/5	1.0
7.2.4	When delegating responsibilities my supervisor gives me authority to make the necessary decisions	4	4	4	4	4	5/5	1.0
7.2.5	I am required to perform tasks that are not covered by my scope of practice	4	4	4	1	3	4/5	1.0
7.2.6	I am assertive in speaking out for my own rights in terms of a fair work environment	3	4	4	4	4	5/5	1.0
7.3	**D :3 Autonomy**							
7.3.1	My supervisor gives me autonomy to determine the outcomes in my ward/unit	4	4	3	4	4	5/5	1.0
7.3.2	My supervisor allows me to control work conduct in my unit	3	3	4	4	4	5/5	1.0
7.3.3	Autonomy is actively cultivated among nurses in the organisation	3	4	3	4	3	5/5	1.0
7.3.4	My supervisor encourages me to	3	4	4	4	4	5/5	1.0

	perform at my best							
7.3.5	I have discretional power to allocate responsibilities to my subordinates	3	3	4	3	4	5/5	1.0
7.4	**D 4: Impact**							
7.4.1	My supervisor listens to my ideas	4	4	3	4	4	5/5	1.0
7.4.2	My supervisor provides me with feedback which enables me to grow	1	4	4	3	4	4/5	0.80
7.4.3	My supervisor acknowledges my contribution to my patients' wellbeing	3	4	4	4	3	5/5	1.0
7.4.4	My supervisor recognises my ability to influence job outcomes	3	3	4	3	4	5/5	1.0
7.4.5	My supervisor allows me to interact with colleagues to improve nursing practice	3	3	4	4	4	5/5	1.0
8	**SECTION E: Positive work behaviours and attitudes**							
8.1	**E :1 Job satisfaction**							
8.1.1	I receive a fair salary for the work that I do	1	3	3	4	4	4/5	0.80
8.1.2	The work climate in the ward where I am working is free from harassment	1	3	4	4	4	4/5	0.80
8.1.3	My work climate is not challenging	1	1	1	4	3	2/5	0.40
8.1.4	My supervisor is approachable	4	3	4	3	4	5/5	1.0
8.1.5	I am expected to regularly perform non-nursing tasks	4	3	1	4	1	3/5	0.60

8.2	**E 2: Commitment**							
8.2.1	My supervisor ensures that relevant in-service training is conducted	4	3	4	3	4	5/5	1.0
8.2.2	My supervisor ensures effective utilisation of resources	4	3	4	4	4	5/5	1.0
8.2.3	My supervisor is committed to effective patient care	4	3	4	4	4	5/5	1.0
8.2.4	My supervisor assists in preparing for promotions	1	4	3	4	4	4/5	0.80
8.2.5	My supervisor's leadership style engenders commitment among nurses	1	3	4	3	1	3/5	0.60
8.3	**E 3: Low stress**							
8.3.1	I am treated with respect by my seniors	3	4	3	4	4	5/5	1.0
8.3.2	The nurses in my ward/unit are overloaded with work	4	2	4	4	4	4/5	0.80
8.3.3	My organisation promotes lifelong learning	4	3	4	4	1	4/5	0.80
8.3.4	My organisation has a career development plan for every employee	4	3	2	4	4	4/5	0.80
8.3.5	Allocation of tasks is according to individual's abilities	3	3	4	4	4	5/5	1.0
8.3.6	My supervisor handles conflict within the ward/unit	4	3	4	4	4	4/5	1.0

	in a timely and effective manner							
8.4	**E :4 Low burnout**							
8.4.1	My supervisor is judgemental about everything I do	1	2	4	4	1	2/5	0.40
8.4.2	I do not have enough time to effectively attend to my patients' needs	4	3	1	4	1	3/5	0.60
8.4.3	I am required to work overtime on a regular basis	4	3	2	4	4	4/5	0.80
8.4.4	My work environment is noisy	4	2	4	4	4	4/5	0.80
8.4.5	I am not given authority to control my job related tasks but is held accountable	1	3	1	4	4	3/5	0.60
8.4.6	The workload and tempo is so high that I never seem to catch up with everything I need to do	4	4	3	4	1	4/5	0.80
9.	**SECTION F: Organisational structure**							
9.1	Nurses in my unit are given authority to act according to their post levels	4	4	4	3	4	5/5	1.0
9.2	My supervisor adheres to an open door policy	3	4	4	3	4	5/5	1.0
9.3	I have more than 15 subordinates reporting to me	1	3	3	4	4	4/5	0.80
9.4	I have the authority to institute disciplinary measures against my subordinates	3	3	4	4	4	5/5	1.0

9.5	I have the right to initiate a grievance process when aggrieved	3	2	4	4	4	4/5	0.80

SECTION G: OPEN-ENDED QUESTIONS

Please read each item and score it for its relevance in representing the concept of empowerment of registered nurses and nurse managers.

Relevance Rating Scale

1. = Not relevant (NR)
2. = Somewhat relevant (SR)
3. = Quite relevant (QR)
4. = Highly relevant (HR)

	ITEMS	Expert 1 Nurse manager	Expert 2 Nurse manager	Expert 3 Nurse manager	Expert Nurse educator	Expert 5 Registered nurse	No of experts	CVI
	OPEN-ENDED QUESTIONS							
1.	What challenges problems do you experience regarding your decision-making role in your organisation?	4	4	4	3	4	5/5	1.0
2.	What kind of assistance do you receive from your supervisor regarding delegated tasks?	3	3	4	4	2	4/5	0.80
3.	Indicate the most important barriers to your performance in the organisation.	4	4	3	4	2	4/5	0.80
4.	Indicate any resources which might enhance the performance of your allocated duties.	4	4	3	3	4	5/5	1.0
5.	How do you assist your supervisor to	3	4	4	3	4	5/5	1.0

	make job related decisions?							
6.	Why do you feel that the nurses are overloaded/not overloaded with work in your ward?	3	3	4	3	3	5/5	1.0
7.	How do you exert authority to control your job related duties	3	4	4	3	4	5/5	1.0

In this study all items with the Content Validity Index below 0.60 are considered to be poor and unacceptable (Sekaran & Bougie 2013:293). Two (2) items; one with a group of five items testing job satisfaction, and one with a group of six items testing burnout obtained a score of 0.40 which is below 0.60 level. These items were retained in the questionnaire and their responses were analysed but were noted as limitations due to their poor content validity.

ANNEXURE F: VALIDATION OF THE GUIDELINES

VALIDATION OF THE EMPOWERMENT GUIDELINES

GUIDELINES FOR THE EMPOWERMENT OF PROFESSIONAL NURSES IN THE PUBLIC HOSPITALS OF ONE DISTRICT IN THE MPUMALANGA PROVINCE

TO:
Nurse managers, guideline experts, supervisors (area managers) nurse educators, and registered nurses.

SUBJECT: Development of empowerment guidelines with regard to a doctoral Study (DLitt et Phil) at the University of South Africa in the Department of Health Studies

RESEARCH TOPIC:
GUIDELINES FOR THE EMPOWERMENT OF PROFESSIONAL NURSES IN THE PUBLIC HOSPITALS OF ONE DISTRICT IN THE MPUMALANGA PROVINCE

The anticipated value of the empowerment guidelines (research study) will depend on your responses to the development of these empowerment guidelines. Your input will enable the researcher to refine the empowerment guidelines and draw certain conclusions and to make recommendations. It is hoped that the empowerment guidelines will be useful in enhancing the empowerment of nurse managers and registered nurses.

Please Note: Read all the guidelines carefully before attempting to rate each guideline. Comment according to your personal knowledge concerning the various guidelines. Give honest inputs reflecting your point of view with no regard to whether it is positive or negative. The following has relevance:

- All the information will be treated in confidence and will serve no purpose other than to gain information on the guidelines.
- Do not give or sign your name anywhere on the guidelines.
- That no monetary benefits or incentive will be provided for participating.

Thank you for your participation and anticipated inputs in the validation of guidelines.
Researcher: Miss Constance Siphiwe Peggy Lephoko (Lecturer)
Mpumalanga College of Nursing
Private Bag X1005
KABOKWENI
1245

INFORMED CONSENT FORM

TITLE: GUIDELINES FOR THE EMPOWERMENT OF PROFESSIONAL NURSES IN THE PUBLIC HOSPITALS OF ONE DISTRICT IN THE MPUMALANGA PROVINCE

Dear Expert

I, Constance S P Lephoko, am a Doctoral (D Litt et Phil) student at UNISA in the Department of Health Studies. I am conducting a research study on the empowerment of nurse managers and registered nurses in the Mpumalanga Province within the Ehlanzeni District.

The purpose of the study is to determine what empowerment encompasses and to establish the reasons for the perceived lack of empowerment of registered nurses. Furthermore, to develop empowerment guidelines which managers can apply in order to enhance the empowerment of registered nurses in their service, and in turn cultivate confident nurse leaders.

You are hereby kindly requested to participate in this study by assessing the empowerment guidelines developed by the researcher. Your anonymity will be ensured as your name and the name of your hospital will not be required on the questionnaire.

I ..... agree to participate in the validation of the noted empowerment guidelines.

I understand:

- The study objectives.
- That the participation is voluntary.
- That I can withdraw from the study at any time without penalty.
- That no monetary benefits nor incentive will be provided for participating

I freely and voluntarily give my consent to participate in the validation of the empowerment guidelines.

_____ _____ _____

SIGNATURE **PRINT NAME** **DATE**

_____ _____

RESEARCHER'S SIGNATURE **DATE**

EMPOWERMENT GUIDELINES ASSESSMENT TOOL

BIOGRAPHIC DATA

Complete the following information pertaining to your personal information

To answer, tick the response in the appropriate box

Question 1: What is your qualification?

Academic Qualifications	Answer
Doctoral degree	
MA Cur degree	
B Cur degree	
Diploma in nursing	

Question 2: What is your current position (rank) within your institution?

Position/rank	Answer
Nurse manager	
Nurse educator	
Supervisor (area manager)	
Registered nurse	

Question 3: Indicate your area of expertise

Guideline experts	Answer
Nursing administration/management	
Operational manager	
Clinical preceptor	
Nurse education	
Quality assurance	
Occupational health	
Infection prevention and control	
Other	

Question 4: Indicate your employer in the appropriate box

Employer	Answer
University	
College/nursing school	
Nursing practice	
Other	

Please indicate other information regarding your expertise that you would consider important to the researcher.

_____

_____

_____

_____

EMPOWERMENT GUIDELINES ASSESSMENT TOOL

Please rate the empowerment guidelines by using following criteria:

1 = Not acceptable. Need major changes

2 = Acceptable with recommendations

3 = Acceptable as described

Please state any input that you wish to add pertaining to any of the guidelines in the space provided in table 5.1. Should you wish to amend or alter a specific guideline then please specify the guideline in your comment.

Criteria and rating scale used for the evaluation of guidelines

Criteria	Rating scale			Expert's comments
	1	2	3	
1. **Validity:** -Correct interpretation of available evidence so that the implementation of guidelines will lead to the facilitation of empowerment of nurse managers and registered nurses.				
2. **Reliability:** -Given the same event/situation, another professional would implement them the same way.				
3**. Clarity:** -Guidelines should be precise, unambiguous and user-friendly.				
4. **Credibility:** -Guidelines are based on the true findings				
5. **Comprehensiveness:** -Address all aspects of empowerment				
6. **Applicability:** -Guidelines should explicitly state the population (population of registered nurses) to which statements apply.				

Adapted from Swardt (Annexure XVII) and Leech et al (2007:110)

THE THEORETICAL FRAMEWORK FOR THE STUDY

KANTER'S THEORY OF STRUCTURAL EMPOWERMENT

Empowerment of nurses in various forms equips them to perform their responsibilities in a manner that positively affects their service delivery to patients. In this study, Kanter's *Theory of Structural Empowerment* will be used to focus on the empowerment of registered nurses. The *Theory of Structural Empowerment* was developed by Rosabeth Moss Kanter. She believes that access to empowerment structures is enhanced by specific job characteristics and interpersonal relationships that foster effective communication (Laschinger et al 2009:229).

Kanter's *Theory of Structural Empowerment* emphasises the importance of giving power to employees in order for them to accomplish their tasks (Lucas et al 2008:965). Power is defined as having the ability to create, get, and use resources to achieve one's goals

(Kelly 2008:689). Power is necessary in order to be able to influence an individual or group. Nurses need power to influence patients, physicians, and other health care professionals, as well as each other. Powerless nurses are ineffective and less satisfied with their jobs (Manojilovich 2007:2).

According to Lucas et al (2008:965), Kanter's *Theory of Structural Empowerment* is divided into three components: component one is concerned with *structural empowerment,* which includes the dimensions of opportunity, information, support, resources, formal power and informal power. Component two is concerned with *psychological empowerment,* which includes meaning, confidence, autonomy and impact as dimensions. Component three is concerned with *positive work behaviours and attitudes* and includes job satisfaction, commitment, low stress and low burnout as dimensions.

Table 2.1 Key components of Kanter's *Theory of Structural Empowerment*

Structural empowerment	**Psychological empowerment**	**Positive work behaviours and attitudes**
Opportunity	Meaning	Job satisfaction
Information	Confidence	Commitment
Support	Autonomy	Low stress
Resources	Impact	Low burnout
Formal power		
Informal power		

Adapted from Lucas, Laschinger and Wong (2008:965)

Please rate the following empowerment by using the assessment tool provided to you.

Structural empowerment

The component of *structural empowerment* consists of six dimensions, namely opportunity, information, support, resources, formal power and informal power. In this component the researcher formulated a guideline on the dimension of resources which was found to be an inhibiting factor for the execution of allocated duties. No guidelines were formulated for the following dimensions: opportunity, information, support, formal and informal power, as the respondents reported that they felt empowered in these areas.

From the dimension of resources under the component of *structural empowerment*, a guideline was formulated which addresses the availability of resources in the workplace which are needed to enable nurse managers and registered nurses to perform their functions effectively. This guideline is based on the views reported by the respondents as indicated in box 5.1.

Box 5.1 Summary of concluding statements regarding the dimension of resources in the workplace

Respondents perceived the dimension of resources as not being empowering because they felt that they were not provided with:

- Adequate personnel to enable them to meet organisational goals
- Necessary equipment to execute allocated tasks
- Sufficient supplies necessary for their jobs and patient care

Respondents indicated the following as the most important resource barriers to their performance in the organisation:

- Lack of material resources/equipment
- Shortage of nursing staff and doctors

Respondents identified the following aspects pertaining to resources which would enhance the performance of their allocated duties as:

- More competent nurses should be employed
- Medical equipment
- Computers
- Training and in-service training on basic computer skills.
- Neonatal training

- **Guideline 1: Provide adequate and sufficient resources in the workplace**

Rationale for implementing the guideline

By implementing this guideline, sufficient resources of the required nature, would provide the means for nurses to perform their allocated tasks and professional responsibilities without difficulties, thus enhancing patient care, staff satisfaction and a sense of achievement.

Recommendations for the implementing of the guideline on resources

In dealing with a shortage of resources, attention should not only be given to the acquisition and utilisation of these resources but also to the training and development of staff who have to order, motivate for, utilise and maintain the existing resources in a cost-effective manner.

In view of the following resources, management is advised to:

Human resources

- Conduct surveys twice a year to assess the nurse-patient ratio in order to determine the staffing needs of each nursing unit and present the identified needs to relevant authorities for managerial support.
- Identify employees who do not possess basic computer skills and motivate for their development by submitting their names to the skills development section for relevant training. Basic computer skills will assist in empowering nurses by enabling them to access medical and nursing expertise, develop problem-solving skills and search for information that they might need in order to improve the nursing care provided to patients.
- Encourage nursing unit managers and registered nurses to formally communicate their resource needs to managers to make them aware of the resource limitations which hamper optimal care.
- Create opportunities for growth by allowing nurses to identify their own learning needs with the assistance of their supervisors in order to facilitate professional

development and personal growth of employees, thus increasing the number of competent nurses.

- Monitor the implementation of the Skills Development Act no 97 of 1998; to assist employees in acquiring new skills that are necessary for accomplishing delegated duties.

Equipment

- Provide adequate medical equipment and advise nurse managers and registered nurses on how to store and utilise the equipment correctly to prolong the working life of the equipment and promote the safety of patients.
- Monitor the acquisition and utilisation of equipment in order to be able to identify areas in which nurse managers and registered nurses need to be developed with the aim of improving their knowledge and skills in acquiring, using, controlling and condemning equipment.

Material resources

- Monitor the acquisition and utilisation of material resources in order to be able to identify areas in which nurse managers and registered nurses need to be developed with the aim of improving their knowledge and skills relevant to material resources.
- Monitor whether unit managers and registered nurses are familiar with the institutional procedure for the procurement of material resources to promote adherence to the institutional regulations.

In-service training programme

- Develop an in-service training programme on budgeting and procurement processes, effective utilisation of equipment, facilities and supplies to empower nurse managers and registered nurses.
- Conduct in-service training in basic computer skills to enable nurse managers and registered nurses to access information that is necessary for accomplishing delegated responsibilities.

Collaboration with Provincial department of Health

- Collaborate with the Mpumalanga Provincial Department of Health through meetings in order to present the views of respondents with regard to the availability of resources in the eight public hospitals of one district in the Mpumalanga Province.

Psychological empowerment

The following section pertains to the second component of Kanter's *Theory of Structural Empowerment.* The dimensions of this component include meaning, confidence, autonomy and impact. In this study the dimension of confidence was replaced with competence as discussed in Chapter 2 in section 2.3.2 (*psychological empowerment*). According to the findings of the study, the respondents felt empowered regarding three dimensions of *psychological empowerment* but felt less empowered regarding the dimension of competence, in particular having to perform tasks that are not covered by their scope of practice. Based on the results the formulated guideline focused on the dimension of competence.

Based on the dimension of competence in the component of *psychological empowerment,* a guideline was formulated which addresses the perceived lack of adherence to the scope of practice in nursing practice. This aims at empowering nurse managers and registered nurses on the allocation of tasks according to the knowledge, skills and abilities of the nurse within the ambit of regulation relating to the Scope of Practice of registered nurses and midwives R2598 of 2005.

Box 5.2 Summary of concluding statement regarding the dimension of competence in the workplace

Respondents perceived the dimension of competence as not being empowering because they were:

- Required to perform tasks that were not covered by their scope of practice.

- **Guideline 1: Allocate tasks to registered nurses according to the scope of practice based on the knowledge, skills and abilities of each nurse**

Rationale for implementation of the guideline

It is envisaged that the allocation of tasks according to the scope of practice of registered nurses will empower nurse managers and registered nurses if tasks are allocated based on the knowledge, skill and abilities of a nurse and will thus decrease tension and promote psychological empowerment through autonomous decision-making.

Recommendations for the implementation of the guideline for the dimension of competence

Management is advised to:

- Adhere to the scope of practice of the different categories of nurses when allocating tasks to subordinates; this will allow nurses to be confident in utilising their relevant knowledge, skills and expertise when performing allocated responsibilities.
- Encourage nursing unit/ward managers to give unambiguous instructions and a precise description of tasks allocated to enable a clear understanding by the subordinate of what is required of him/her; for example by giving guidance, coaching, and hands-on assistance where nurses are faced with challenging tasks pertaining to patient care.
- Create opportunities for nurses to network with other nurses in the organisation and outside the organisation to engender an atmosphere for sharing of ideas and information in order to improve nurses' competence.
- Draw and implement developmental plans to address nurses' performance deficiencies based on the identified learning and or developmental needs in order to enhance proficiency and the empowerment of nurses.

Positive work behaviours and attitudes

The component of *positive work behaviours and attitudes* is the third and last of Kanter's *Theory of Structural Empowerment.* This component comprises of job satisfaction, commitment, low stress and low burnout.

The dimension of job satisfaction

The guideline on the dimension of job satisfaction addresses the unfair salaries as perceived by employees and the creation of promotional and career planning opportunities for nurses which might improve job satisfaction of employees in the workplace.

Box 5.3 Summary of concluding statements regarding fair salaries in the workplace

Respondents' views on unfair salaries/remuneration in relation to the work they do. **Respondents considered salaries/remuneration as not being empowering because:** • They did not receive fair salaries

- **Guideline 1: Implement the Public Service Act 1994 (proclamation No 103 of 1994) section 37 (1) to establish a foundation for the remuneration of officers and employees.**

By implementing the Public Service Act 1994 (proclamation No 103 of 1994) section 37 (1) a fair and comprehensive remuneration is provided to employees.

Recommendations for implementation of the guideline for the dimension of job satisfaction

Management is advised to:

- Monitor whether performance appraisals are conducted according to set standards to ensure that employees who are ready for promotion are identified

and promoted if posts are available; this will assist in addressing the remuneration packages of employees where it is deserved.

- Nominate employees whose performance is above the set standards, who qualify for incentive bonuses and pay progression and present them to the performance management development moderation committee (PMDMC) in order to be able upgrade their salaries.

Guideline for the dimensions of low stress and low burnout

This guideline addresses the high work load nurses experience which leads to increased levels of stress and burnout, and it aims at empowering nurse managers and registered nurses on how to create workplace environments that lessen stress and burnout levels in employees.

Box 5.4 Summary of concluding statements regarding the workload in the workplace

Due to the workload the respondents carry, they viewed the workplace not to be empowering because they:

- Complained of tiredness
- Found it difficult to take tea and lunch breaks
- Felt overloaded with work due to shortage of staff
- Were unable to catch up with the work they were expected to do.

- **Guideline 2: Manage the workload constructively in the workplace**

Rationale for implementation of the guideline

Implementation of this guideline will empower nurse managers and registered nurses to create workplace environments that lessen stress levels in their ward/units.

Recommendations for implementation of the guideline for the dimension of low stress and low burnout

Management is advised to:

- Increase their own observational skills to detect whether tasks are delegated according to the educational level and capabilities of the employee.
- Provide adequate human resources by motivating for the filling of vacant posts if available to enable nurses to accomplish delegated tasks in a fair and reasonable manner.
- Empower nursing ward/unit managers and subordinates to plan and schedule their work activities by means of sound time management in order to be able to accomplish the set goals; this can be achieved by in-service training which will assist employees in lowering their stress levels.
- Monitor the implementation of the Basic Conditions of Employment Act (No 75 of 1997) which addresses regulation of working time, overtime, mealtime and teatime and daily and weekly rest periods to limit work overload that could lead to physical consequences of stress and burnout.
- Provide information to employees about the availability of employee assistance programmes. Employees who show stress-related symptoms are to be referred for professional counseling in order to enable them to deal with their stressful challenges.
- Provide managerial support by means of open communication and genuine commitment for nurses who have a need to discuss difficulties at work and express experiences of work overload.
- Develop an employee retention strategy whereby job satisfaction is enhanced and staff turnover is reduced to minimise the shortage of nurses.

VALIDATION OF THE GUIDELINES

To determine the feasibility and accessibility of the developed guidelines, the researcher set out to have the guidelines assessed by nursing practitioners in different fields of nursing. The researcher selected experts and requested them to participate in the evaluation of the guidelines. The experts were provided with a copy of the proposed guidelines, a copy of the theoretical framework used as the foundation of the study and

a covering letter explaining why the guidelines were developed, and an explanation of how the validation should be conducted (Annexure F). The experts were also given a validation form with the rating scale explaining how the instrument should be used when evaluating the guidelines. The researcher selected twelve (12) experts and requested them to validate the empowerment guidelines.

The outcome of the validation process is indicated in (Annexure F). The experts were two nurse managers, four nurse educators, one clinical preceptor, 3 registered nurses and two supervisors (area managers). The experts were requested to validate the guidelines according to the rating scale and criteria: validity, reliability, clarity, credibility, comprehensiveness and applicability. The experts were also asked to assess and evaluate the guidelines on their own to avoid the possibility of influencing each other. One evaluator (nurse manager) did not give feedback on the evaluation of the guidelines despite being reminded by the researcher several times. Table 5.1 indicated the attributes of the experts. The attributes included: position, employer, expertise and academic qualifications.

Attributes of the experts (n=12)

Descriptor	**Frequency**
Position	
Nurse manager	2
Nurse educator	4
Clinical preceptor	1
Registered nurse	3
Supervisors of nursing units (area managers)	2
Employed by	
University	2
College/Nursing school	1
Clinical practice	8
Regulatory body (SANC)	1

Expertise	
Guideline experts	3
management	2
Operational managers	2
Clinical preceptor	1
Education	1
Quality assurance	1
Occupational health	1
Infection prevention and control	1
Academic qualifications	
Doctoral degree	2
Master's degree	2
B Cur in nursing science	4
Diploma	4
Total	**12**

Results of validated guidelines

Criteria	**Not accepted**	**Accepted with recommendations**	**Accepted as described**	**Comments from experts**
Validity	1	2	8	-The guidelines were derived from the findings. -The guidelines are valid because they are based on evidence.
Reliability	1	2	8	Reliable, if the emphasis is on the chosen dimension of Kanter's theory of structural empowerment used for the development of the guidelines.

				-Any professional can use the guidelines. -The guidelines can be easily implemented by anyone.
Clarity		2	8	-The guidelines are clear.
credibility	1	2	9	-The guidelines contain what is directly affecting nurses in the Mpumalanga Province.
Comprehensiveness	1	3	7	There was emphasis on the specific dimension of Kanter's theory of structural empowerment. -All the three aspects of empowerment have been addressed.
applicability		3	8	-The population which the statements applied to has been indicated in all the guidelines and addressed

The evaluators' comments on the empowerment guidelines:

***Validity*:** The evaluators indicated that the guidelines were derived from the findings and further indicated that guidelines were valid because they were based on evidence.

Reliability: The guidelines were considered to be reliable as the emphasis was on the chosen theoretical framework of Kanter's *Theory of Structural Empowerment* for their development. Other comments indicated that any professional could use the guidelines, and they could easily be implemented by any nurse.

***Clarity*:** The evaluators mentioned that the guidelines were clear.

***Credibility*:** The guidelines were reported to be containing what directly affected registered nurses in the Mpumalanga Province**.**

***Comprehensiveness*:** The evaluators indicated that the guidelines emphasised the specific dimensions of Kanter's *Theory of Structural Empowerment*, and all three of the aspects (components) of the theory were addressed.

Applicability: The evaluators reported that the population to which recommendations (statements) applied was clearly addressed in all the guidelines.

ANNEXURE G: LETTER FROM STATISTICIAN

23 September 2014

RE Statistical analysis of the Doctoral dissertation: ‘‘GUIDELINES FOR THE EMPOWERMENT OF PROFESSIONAL NURSES IN THE PUBLIC HOSPITALS OF ONE DISTRICT IN THE MPUMALANGA PROVINCE’’

To whom it may concern

This serves to confirm that HJ Gerber (trading as HR Statistics) was involved in the empirical research efforts of Ms Constance Siphiwe Peggy Lephoko for her DLitt et phil study.

HR Statistics can vouch for the accuracy of the statistical evaluation undertaken for the empirical chapter of the student’s dissertation “**GUIDELINES FOR THE EMPOWERMENT OF PROFESSIONAL NURSES IN THE PUBLIC HOSPITALS OF ONE DISTRICT IN THE MPUMALANGA PROVINCE’’**

Although every effort was made to ensure that the student presented the statistical results correctly, HR Statistics cannot accept responsibility for the structure and presentation of the results of this study.

Kind Regards

Hennie Gerber

ANNEXURE H: LETTER FROM EDITOR

Certificate of Language Editing

This is to certify that I have conducted the language editing of the thesis

GUIDELINES FOR THE EMPOWERMENT OF PROFESSIONAL NURSES IN THE PUBLIC HOSPITALS OF ONE DISTRICT IN THE MPUMALANGA PROVINCE

By

CONSTANCE SIPHIWE PEGGY LEPHOKO

Submitted in accordance with the requirements for the Degree of
DOCTOR OF LITERATURE AND PHILOSOPHY
in the subject
Health Studies
at the
University of South Africa

Student number: 04623606

Sannie Meiring
15 January 2017